

# VEIN PATIENT DATA FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Blood Type: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

## PERSONAL MEDICAL HISTORY (CURRENT COMPLAINT)

1. Are you consulting for: Cosmetic Purposes Medical Reasons Both

2. Have you ever been treated for varicose veins? If so when and by whom?

3. Have you every been treated for one of the following?

- Phlebitis (inflammation of a vein)  
 Right leg  Left leg - Hospitalization ?  Yes  No When? \_\_\_\_\_
- Leg ulcer  
 Right leg  Left leg - Hospitalization ?  Yes  No When? \_\_\_\_\_
- Pulmonary embolism / blood clots  
 Right leg  Left leg - Hospitalization ?  Yes  No When? \_\_\_\_\_
- Leg fracture?  Yes  No When? \_\_\_\_\_  
 Right leg  Left leg - Hospitalization ?  Yes  No When? \_\_\_\_\_

4. When did your veins problems start?

- Age \_\_\_\_\_
- Before pregnancy  Yes  No
- During pregnancy  Yes  No
- After birth control or Estrogen therapy  Yes  No
- After trauma  Yes  No
- Other \_\_\_\_\_

5. Has your veins progressively worsened with time?  Yes  No

6. Indicate which of the following problems you have experienced:

- **Pain in your:**
  - Lower limbs  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Thighs  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Legs  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Feet  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Swelling of the legs  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Ulcerations  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Bleeding  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Fatigue  Right Leg  Left Leg How many years? \_\_\_\_\_
  - Others  Right Leg  Left Leg How many years? \_\_\_\_\_

Specify \_\_\_\_\_

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7. If you experience pain in your lower limbs:

• **Is the pain increased by:**

- Extended period of standing  Yes  No  
Heat  Yes  No  
Menstrual periods  Yes  No  
Exercising and / or walking  Yes  No  
Medications  Yes  No  
Others  Yes  No

Specify \_\_\_\_\_

• **Is the pain reduced by:**

- Elevation of the limb  Yes  No  
Compressive stockings  Yes  No  
Walking and / or exercising  Yes  No

• **Indicate the type of pain:**

- Pain while resting  Yes  No  
Cramping while resting  Yes  No  
Night cramps  Yes  No  
Tiredness  Yes  No  
Heaviness in the legs  Yes  No  
Pain in specific areas  Yes  No  
Numbness  Yes  No  
Burning sensation  Yes  No

Additional comments: \_\_\_\_\_

8. Do you have a **family history** of:

- Varicose veins problems  Yes  No Family Member \_\_\_\_\_  
• Phlebitis  
(Inflammation of the vein)  Yes  No Family Member \_\_\_\_\_  
• Blood Clots  Yes  No Family Member \_\_\_\_\_  
• Leg ulcers  Yes  No Family Member \_\_\_\_\_  
• Cancer  Yes  No Family Member \_\_\_\_\_

9. Do you have a history of:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Seizures /Convulsions    | <input type="checkbox"/> Fainting or dizzy spells   | <input type="checkbox"/> Hives         |
| <input type="checkbox"/> Blood transfusions       | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Septicemia    |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Thrombophlebitis           | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> Bleeding disorder        | <input type="checkbox"/> Deep vein thrombosis (DVT) | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> HIV Positive (AIDS test) | <input type="checkbox"/> Easy bruisability          | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Autoimmune disease       | <input type="checkbox"/> Pulmonary embolus          | <input type="checkbox"/> Dark spots    |

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10. Does your work require:

- Prolong sitting  Yes  No
- Prolong standing  Yes  No

11. In the course of a normal day, how much time do you spend in a standing position?

- 10% of the day       20 %       30% to 50%       more than 50%

12. Does walking or exercise increase or reduce the pain?  Reduce  Increase

13 Do you jog, run, jump rope or do aerobics  Yes  No How often per week \_\_\_\_\_

14. Check all of the following methods have you tried to reduce your discomfort?

- Exercise     Compressive stocking     Weight loss  
 Elevation     Over the counter anti-inflammatory

15. Are you pregnant  Yes  No      Are you planning a pregnancy soon?  Yes  No

16. Do you smoke cigarettes?  Never  
 Yes How many years have you smoked? \_\_\_\_\_  
How many packs per day? \_\_\_\_\_  
 No What year did you quit smoking? \_\_\_\_\_

17. Do you wear compressive stockings?  Yes  No If yes, what compression? \_\_\_\_\_  
• When did you start wearing compressive stockings? \_\_\_\_\_ What compression? \_\_\_\_\_  
• What brand? \_\_\_\_\_  Knee high  Thigh high  Pantyhose  
• How often to you wear compressive stockings? \_\_\_\_\_

18. Are you taking any medications  Yes  No

19. Indicate which of the following you are taking:

- Aspirin       Anticoagulants       Hormones or contraceptives (birth control)  
 Cortisone     Insulin       Chemotherapy for any type of tumor  
 Sedatives     Thyroid medication  Appetite depressants       Tranquilizers  
 Others Specify: \_\_\_\_\_