The Vein Center
at THE PLASTIC AND HAND SURGERY ASSOCIATES

VEIN HEALTH & HISTORY FORM (Page 1 of 2)

Patient Name: _____ Date: _____/_____/_____
Last First Middle

DOB: _____/_____/_____ Are you requesting a vein evaluation for medical reasons? Yes No

What is your chief complaint or medical reason for having a vein consultation?_____

Indicate which of the following signs or symptoms you have experiences: (circle all that apply)

Burning / Itching / Tingling / Heaviness / Fatigue / Pain / Discomfort / Cramping

Generalized Leg Swelling / Ankle Swelling / Restlessness in the Legs / Worsening Leg Veins

Bulging Leg Veins / Bulging Pelvic Area Veins / Prior Phlebitis (Localized Vein Tenderness)

Prior Leg Ulcer / Blood Clots / Ruptured or Bleeding Veins / Deep Vein Thrombosis (DVT)

Pulmonary Embolism (PE) / Thrombophilia (Blood Clotting Disorder)

Do you have a family history of vein disease? Yes No Any family history of blood clots? Yes No

Have you ever smoked tobacco? Yes No Have you ever had a substance abuse problem? Yes No

Are you currently working? Yes No What is your occupation? _____

Are you required to sit/stand for prolonged periods? Yes No Do you walk during your job? Yes No

When did you first become aware that you had a vein problem? _____

If you have worn compression stockings before, please indicate for how many months or years: _____

What relieves your vein symptoms?_____ Don't Know _____

What makes your vein symptoms worse?_____ Don't Know _____

Have you been previously evaluated for a vein problem? Yes No Explain: _____

Indicate which prior vein treatments you have had: (check all that apply) _____ No Prior Vein Treatments

_____ Sclerotherapy Injections _____ Surgical Ligation _____ Surgical Vein Stripping

_____ Ambulatory Phlebectomy _____ Surface Laser/Light _____ Endovenous Laser Ablation

_____ VNUS Radiofrequency Closure _____ Other: _____

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List your current medications: _____

Do you have any medication allergies? Yes No Explain: _____

Do you have a latex allergy? Yes No Explain: _____

List prior surgeries: _____

List prior hospitalizations: _____

List medical conditions you are being treated for: _____

Indicate which of the following conditions below which you have had: (check all that apply) _____ None

_____ Blood Clotting Disorder	_____ Anemia or Bleeding Disorder	_____ Heart Defect or PFO
_____ Migraine Headache	_____ High Blood Pressure	_____ Heart Murmur
_____ Asthma or Lung Disease	_____ Stroke or CVA	_____ Diabetes Mellitus
_____ Coronary Artery Disease	_____ Peripheral Artery Disease	_____ Renal or Kidney Disease
_____ Hepatitis or Liver Disease	_____ Joint Replacement Surgery	_____ Cancer or Malignancy
_____ HIV or AIDS	_____ Hypercholesterolemia	_____ Other: _____

For Women Only

Number of Pregnancies: _____ Number of Children: _____ Ages of Children: _____

Number of Miscarriages: _____ Are you pregnant or planning to get pregnant? Yes No

Do you have any pelvic area varicose veins? Yes No

Do you commonly experience pain with intercourse? Yes No

_____ _____ _____/_____/_____
Patient's Printed Name **Patient's Signature** **Date Signed**

_____ _____/_____/_____ _____ _____/_____/_____
Surgical Technician Date Physician Signature Date