

DATE:
 PATIENT #:
 PATIENT NAME:
 PATIENT DOB:
 PATIENT SEX:

VCC – Patient Venous History

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

	Yes	No
1. Have you had any prior treatments for varicose/spider veins? • Describe _____ • Dates of treatments _____ • Surgery dates _____ • Type of agent(s) used, if known _____		
2. Do you have a history of ulceration, chronic swelling of your leg, or clots? • When? _____		
3. Do you have a family history of varicose / spider veins? • If yes, relationship(s) to you _____		
4. Are you currently, or have been, on any hormone therapy or birth control pills? • If yes, please list _____		
5. Have you had any pregnancies? • If yes, how many? _____ • If yes, did your varicose/spider veins increase after pregnancy? _____		
6. Have you worn support hose? • If yes, more than 6 months? • How many months? _____		
7. Are you presently employed? • If yes, type of job _____		
8. Do you sit or stand for long periods of time? • How many hours perday? Sitting _____ Standing _____		
9. Please describe “level of discomfort/pain”, frequency/timing of discomfort/pain, how does it effect your daily life? (this information may be required to pre-certify medical services with your insurance carrier). _____ _____ _____		
10. Have you taken any pain medications for your varicose / spider veins? • If yes, what? _____		
11. Do you elevate your legs to relieve symptoms? • If yes _____ hours per day _____ # months _____ # of years • If yes, does it help? _____yes _____no		

Do you experience any of the following?

- | | | |
|--------------------------------|---------------|--------------|
| • Edema (swelling) | ___ Right leg | ___ Left leg |
| • Discomfort / Pain | ___ Right leg | ___ Left leg |
| • Tiredness/Throbbing/Achiness | ___ Right leg | ___ Left leg |
| • Ulceration | ___ Right leg | ___ Left leg |
| • Skin color changes | ___ Right leg | ___ Left leg |
| • Varicose veins | ___ Right leg | ___ Left leg |