

The Vain Clinic

160 NW Central Park Plaza, Suite 104 • Port St. Lucie, FL 34986 • 772-332-4715

Patient Health History

Name _____ Date _____

Age _____ Sex: M / F

1. Have you ever been in the hospital as a Patient? Yes _____ No _____

If yes, for what reason _____

2. Have you ever had surgery? Yes _____ No _____

If yes, what type of surgery and when _____?

3. Have you ever had vein stripping surgery? Yes _____ No _____

If yes, which leg and when _____

4. Have you ever had sclerotherapy? Yes _____ No _____

If yes, where, which leg, and when _____

5. Are you presently under the care of a Physician? Yes _____ No _____

If yes, for what condition _____

What physician _____

6. Do you have heart disease? Yes _____ No _____

Lung disease? Yes _____ No _____

High Blood Pressure Yes _____ No _____

Hepatitis Yes _____ No _____

Arthritis Yes _____ No _____

Leg Ulcer Yes _____ No _____

7. Have you ever had a blood clot? Yes _____ No _____

If yes, which leg and when? _____

8. Have you ever had phlebitis? Yes _____ No _____

Child Bearing History

1. Do you think you are presently pregnant? Yes _____ No _____

2. How many times have you been pregnant? _____

3. Do you intend to have more children? Yes _____ No _____

4. Are you presently breastfeeding? Yes _____ No _____

Family History

Does anyone in your family have varicose veins, spider veins, leg ulcers or swollen legs?

Father Yes _____ No _____

Mother Yes _____ No _____

Brother(s) Yes _____ No _____

Sister(s) Yes _____ No _____

Other _____ Yes _____ No _____

Personal History

1. Do you have any of the following symptoms?
Aching/Pain in your legs? Yes _____ No _____
Heaviness Yes _____ No _____
Tiredness/Fatigue Yes _____ No _____
Itching/Burning Yes _____ No _____
Swollen ankles Yes _____ No _____
Leg cramps Yes _____ No _____
Restless legs Yes _____ No _____
Throbbing Yes _____ No _____
Other _____
2. Have your veins gotten worse in recent months? Yes _____ No _____
3. Do you elevate your legs to relieve discomfort? Yes _____ No _____
4. Do you wear support stockings prescribed by a doctor? Yes _____ No _____
If yes, what type? _____
5. Do you wear light support hose (e.g. sheer energy) Yes _____ No _____
6. Do they provide relief? Yes _____ No _____
7. Do you have any problem walking? Yes _____ No _____
If yes, describe symptoms _____
8. Do you stand much at work? Yes _____ No _____
At home? Yes _____ No _____
9. How does standing affect your legs? _____
10. Do you smoke? Yes _____ No _____
If so, how many packs per day? _____
11. Have you ever had your veins evaluated before? Yes _____ No _____
If so, when and where? _____
12. Have you ever had any tests on your veins? Yes _____ No _____
If so, why, when and where _____

Current Medical History

1. Do you have any allergies to (medicines, foods, pollen, etc.)? Yes _____ No _____
Please list and describe your reaction (e.g. rash, hives, shortness of breath, etc)

2. Are you allergic to shrimp, shellfish, any form of iodine, or IV contrast?
Yes _____ No _____
3. Are you presently taking any medication including prescription and/or non-prescription (over the counter) medication? Yes _____ No _____
If so, list them _____

4. Do you take any blood thinning medications? Yes _____ No _____
5. Are you taking hormones or birth control pills? Yes _____ No _____