McKenzie Vascular Group

Vein History

Name:_____ Age: _____ DOB: _____ Date: _____

Did your physician refer you to the Vein Clinic? ☐ Did you refer yourself? ☐

Length of symptoms? _____ # months _____ # years

Symptoms:

PLEASE CHECK ALL THAT APPLY TO YOU

Aching / pain in legs	☐ Right ☐ Left _____	Heart Disease	☐
Heaviness	☐ Right ☐ Left _____	Contagious Disease	☐
Tiredness/fatigue	☐ Right ☐ Left _____	Hepatitis	☐
Itching/Burning	☐ Right ☐ Left _____	High Blood Pressure	☐
Leg Cramping	☐ Right ☐ Left _____	Diabetes	☐
Leg Restlessness	☐ Right ☐ Left _____	Cancer	☐
Throbbing	☐ Right ☐ Left _____	Lupus	☐
Swelling	☐ Right ☐ Left _____	Leg Trauma/Surgery	☐
Night Cramps	☐ Right ☐ Left _____	Major Surgery/Hospitalizations	☐
Discoloration	☐ Right ☐ Left _____	Bleeding or Clotting Disorder	☐
Bleeding from a vein?	☐ Right ☐ Left _____		
Ulcerations	☐ Right ☐ Left _____		

*If ulcerations, where were they and have they healed?*_____

_____

Please be very specific with your answers below:

Do your symptoms interfere with your sleep? ☐ Yes ☐ No

How? _____

_____

Do your symptoms interfere with walking? ☐ Yes ☐ No

How? _____

_____

Do your symptoms worsen with or after activity? ☐ Yes ☐ No

How? _____

_____

Do your symptoms affect work or interfere with your job? ☐ Yes ☐ No

How? _____

_____

Do your symptoms affect lifestyle such as maintaining healthy weight? ☐ Yes ☐ No

How? _____

_____

Additional Notes: _____

_____

_____

Name: _____ DOB:_____

Conservative Treatment:

What conservative measures have you used or are currently using to help with the symptoms of your varicose veins?

☐ Pain medication (ibuprofen,etc) ☐ Herbal supplements ☐ Job Change
☐ Leg elevation ☐ Exercise ☐ Weight loss
☐ Compression stockings 20-30 mmHg ☐ Other compression: _____

Are you currently using compression stockings? ☐ Yes ☐ No If yes, how long? _____
Have you worn compression stockings in the past? ☐ Yes ☐ No If yes, how long?_____

Are any of the above helpful? ☐ Not at all ☐Slightly ☐Significantly ☐ Completely resolved my symptoms

Restless Leg Syndrome:

Do you find the need to move your legs to relieve an uncomfortable feeling? ☐ Yes ☐ No
Do your legs feel better when moving them or walking? ☐ Yes ☐ No
Are your legs worse when sitting or resting? ☐ Yes ☐ No
Are your leg symptoms worse later in the day or at night? ☐ Yes ☐ No

Women Only:

Are you pregnant or considering a pregnancy sometime in the future? ☐ Yes ☐ No
Are you breast-feeding? ☐ Yes ☐ No Are your legs more painful associated with menstruation? ☐ Yes ☐ No
Have you been diagnosed with Pelvic Congestion Syndrome? ☐ Yes ☐ No
Pain with and after intercourse? ☐ Yes ☐ No Frequent and sudden need to urinate? ☐ Yes ☐ No
Number of pregnancies? _____ Number of deliveries? _____ Age(s) of Children:_____

Additional Information

Please check box if you have, or have had, any of the following:

A prior evaluation for your veins? ☐ Yes ☐ No
Previous vein surgery or laser treatment? ☐ Yes ☐ No
Previous vein injections? ☐ Yes ☐ No
Have you ever had Venaseal? ☐ Yes ☐ No
Have you ever had thermal ablation? ☐ Yes ☐ No

A family history of vein disease? ☐ Yes ☐ No
If yes, who? _____
A family history of leg ulcerations? ☐ Yes ☐ No
If yes, who? _____
A family history of blood clots in the leg(s)☐ Yes ☐ No
If yes, who? _____