Confidential Health & Vascular History

TotalVeinCare
Comprehensive Treatment of Vein Disorders

TotalVeinCare.net 859.278-4960

PATIENT INFORMATION

Name_____ Date_____

Age_____ Sex_____ Height_____ Weight_____ Years with varicose/spider veins_____

What is it about your legs you would most like to correct?_____

HOW DID YOU HEAR ABOUT US? ❑ TV ❑ Radio ❑ Other _____

Referring Doctor:_____

SYMPTOMS *(Please circle all that apply)* ❑ Red spider veins ❑ Bulging veins ❑ Skin discoloration around ankle
❑ Leg ulcer ❑ Purple veins ❑ Abdominal veins ❑ Other_____

Do your legs or ankles:

Ache or hurt? *Please describe*_____

Swell? *Please describe* _____

Cramp? *Please describe* _____

Become tired/restless? *Please describe* _____

Itch? *Please describe* _____

Other? *Please describe* _____

MEDICAL HISTORY

Is there a history in your FAMILY of varicose or spider veins?

Describe which: Mother _____ Siblings _____
Father _____ Aunt/Uncle_____
Grandparents _____ Child _____

Is there a history in your FAMILY of deep venous thrombosis (DVT), stroke or clotting disorders?

Describe which: Mother _____ Siblings _____
Father _____ Aunt/Uncle_____
Grandparents _____ Child _____

TREATMENT HISTORY

Please circle any methods you have used to relieve your leg discomfort:

❑ No discomfort ❑ Warm Soaks ❑ Leg elevation ❑ Cold packs ❑ Exercise ❑ Pain medication/Anti-inflammatories
❑ Support hose ❑ Other_____

Have you been treated for your veins before? _____

What methods? ❑ Cosmetic Injections ❑ Ultrasound guided injections ❑ Stripping ❑ Radiofrequency closure
❑ Phlebectomy ❑ Laser ablation ❑ Ligation Laser for spider veins ❑ Other:_____

Are you on your feet for long periods of time? _____ **In what capacity?** _____

Does walking/exercise relieve your discomfort or make it worse? _____

FOR WOMEN

Are you pregnant or planning to be soon? _____ **Are you breastfeeding?** _____

Do your veins cause discomfort at the time of your periods? _____ **How many pregnancies thus far?** _____