WATERFORD
VEIN INSTITUTE

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Patient Venous History

Patient Name: _____Date:_____ _____

What is the main reason for your visit today? _____

How long have you had this problem? _____ Years _____ Months

Please check which symptoms you have:

☐ Leg Pain/Cramps ☐ Tired/Heavy Legs ☐ Tenderness ☐ Ankle Swelling ☑ Red Warm Areas
☐ Itching ☐ Aching/Throbbing ☐ Burning ☐ Stinging
☐ Restless Legs ☐ Open Sore/Ulcer ☐ None ☐ Other: _____

On a scale from 0 (none) to 10 (severe), how would you rate your symptoms? _____

Have your symptoms/veins gotten worse in recent months? ☐ No ☐ Yes

Are your symptoms worse with? ☐ Prolonged sitting/standing ☐ Hot Baths ☐ Menstrual Cycle
Are your symptoms improved by? ☐ Rest and Elevation ☐ Walking

Do your symptoms alter your daily activities at work or at home? ☐ No ☐ Yes
If yes, How_____

Do your symptoms alter your leisure activities? ☐ No ☐ Yes
If yes, How_____

Do you stand much at work/home? ☐ No ☐ Yes

How does standing affect your legs? _____

Do you need to stop and rest your legs during the day? ☐ No ☐ Yes

Do you need to rest/elevate your legs at the end of your day? ☐ No ☐ Yes

What is your activity level? ☐ Active ☐ Very Active ☐ Sedentary

Have you ever worn prescription compression stockings? ☐ No ☐ Yes If yes, for how long? _____

Date first worn? _____ First prescribed by? _____

Pressure: ☐ < 20 mmHg ☐ 20-30 mmHg ☐ 30-40 mmHg

Type: ☐ Knee-hi ☐ Thigh-hi ☐ Pantyhose

Any improvement of symptoms with stockings? ☐ No ☐ Yes

Have you taken any medications (prescription/ over the counter) for your symptoms? ☐ No ☐ Yes If yes:

Name and dosage _____ How many times per day? _____

Any improvement of symptoms with medications? ☐ No ☐ Yes

Have you ever had treatment for veins? ☐ No ☐ Yes

If yes, explain_____

Were your veins made worse by pregnancy? ☐ No ☐ Yes

Total number of pregnancies you have had: _____ How many children? _____ # of miscarriages? _____

Family History of Varicose or Spider Veins (please check):

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Uncle ☐ Aunt ☐ None

Patient Signature _____Date _____

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