



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 \_\_\_\_\_