Name:

Date of Birth:

Varicose Vein History

Who referred you?

Primary care physician?

Where is pain of legs?

How would you rate leg pain? (0-10) 10 is severe

How long have you had leg pain?

How do you relieve leg pain?

Do you currently wear prescription/Over-The-Counter compression stockings? (insurance payment for treatment usually requires 3 months of wearing stockings before approval)

If yes, then how long have you worn them? (insurance payment for treatment usually requires 3 months of wearing stockings before approval)

Do they relieve pain?

Do you have open areas of legs? Please describe

Have you had previous open areas of legs that were difficult to heal? Please describe

Do you have itching of the legs?

How would you rate the itching? (0-10) 10 is severe

Have you had previous vein treatments? Please describe

Have you had previous ultrasound exam for leg varicose veins?

Have you had a previous Deep Vein Thrombosis (leg clot)/Pulmonary Embolism (lung clot)? (if yes, how were you treated?)

Have you been diagnosed with a vein clotting disorder?

Have you been treated with blood thinners in past or currently? (Coumadin, Heparin)

Do you have migraine headaches? (if yes, how frequently?)

Have you been diagnosed with a "hole of the heart"/Patent Foramen Ovale(PFO)?

Medical problems/treatments (check all that apply):

- □ Diabetes
- □ CABG (Coronary/Heart Artery Bypass Graft)
- □ Coronary/Heart Stent
- □ MI/Heart Attack
- □ High Blood Pressure
- □ Stroke
- □ Other medical problems? Please list and describe

Allergies: Please list and describe reaction

Do you smoke? (if yes, how long have you smoked?)

Do you have children? (if so, how many?)

Please list all medications, dose and how often you take them: