John V. White, MD
Vascular Surgery

Date_____

Patient Name: _____ **Date of Birth:** _____

Please respond to the following questions. Provide estimates for date of occurrence.

Varicose Vein History

1. When did you first notice varicose veins? _____

2. When did your varicose veins begin to bother you? _____

3. Have you ever had any test(s) done to evaluate your veins? ☐ Yes ☐ No
   If yes, what type of test? ☐ Reflux ☐ Ultrasound/Duplex ☐ Venogram ☐ Other _____

   Where was test done and when? _____

4. Have you ever had any prior treatment of your varicose veins? ☐ Yes ☐ No
   If yes, what type of treatment?

   Vein stripping surgery? ☐ Yes ☐ No

   If yes, when and which leg? _____

   Laser therapy or radiofrequency ablation? ☐ Yes ☐ No

   If yes, when and which leg ? _____

   Injection sclerotherapy (vein injections)? ☐ Yes ☐ No

   If yes, when and which leg? _____

5. Have you ever had a blood clot (DVT)? ☐ Yes ☐ No

   If yes, which leg and when? _____

   How was this treated? ☐ Heparin ☐ Coumadin (warfarin) ☐ Aspirin ☐ No Treatment

6. Have you ever had phlebitis (redness/inflammation)? ☐ Yes ☐ No

   If yes, which leg and when? _____

7. Have you ever had a venous ulcer? ☐ Yes ☐ No

   If yes, which leg and when? _____

   How was this treated? ☐ UNNA boot ☐ Compression stocking/wrap ☐ Antibiotics ☐ No Treatment ☐ Other _____

8. Do you have any bleeding or clotting disorders? ☐ Yes ☐ No

9. Have your veins gotten worse in recent months? ☐ Yes ☐ No

   Describe: _____

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10. Do you experience any of the following symptoms in your legs?

Aching/pain?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Heaviness?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Tiredness/fatigue?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Itching/burning?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Swollen ankles?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Night cramps?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Restless legs?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs
Throbbing?	☐ Yes ☐ No	☐ LT ☐ RT	☐ Both legs

Other?_____

11. Do your symptoms interfere with your work or daily activities? ☐ Yes ☐ No

If yes, how? _____

12. Have you ever had varicose veins of the labia or vulva? ☐ Yes ☐ No

13. Do you ever experience any pelvic discomfort or pain? ☐ Yes ☐ No

If yes, when? ☐ Standing
☐ Straining
☐ Lifting
☐ Intercourse
☐ Other (please describe) _____

14. Do you take any medication for your vein symptoms (i.e., Advil, Motrin) ☐ Yes ☐ No

If yes, what medication(s) do you take and how many times/mgs per day? _____

_____

15. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No

If yes, how long per day do you elevate and does it provide relief? _____

_____

16. Do you exercise? ☐ Yes ☐ No If yes, what kind of exercise and how often?

_____

17. Do you wear <u>prescription</u> compression stockings? ☐ Yes ☐ No

If yes, what type? _____How long have you worn them? _____

18. Do you wear light support hose (i.e., Sheer Energy)? ☐ Yes ☐ No

19. Do you have any problem walking? ☐ Yes ☐ No

If yes, describe _____

20. What type of work do you do? _____

How long do you stand (hours per day) at work? _____ At home? _____

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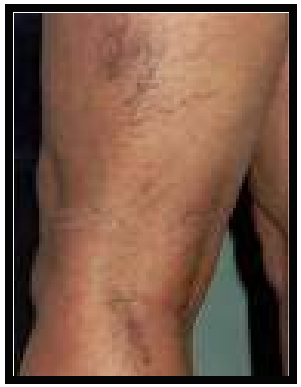
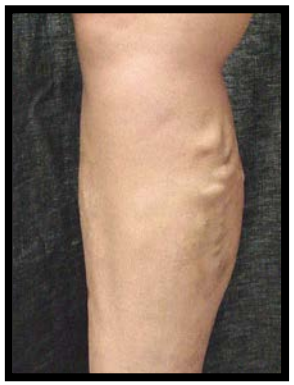
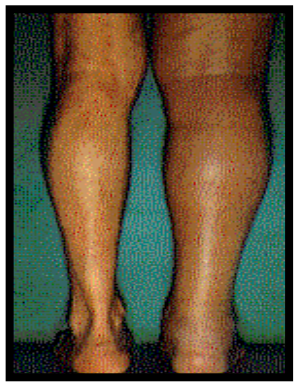
Please place a check under the picture that best illustrates your vein problem



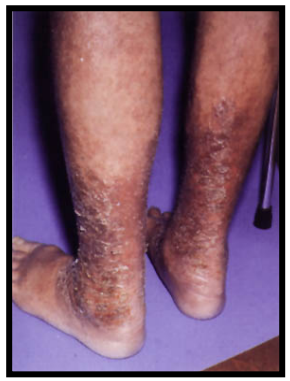
☐ Spider Veins



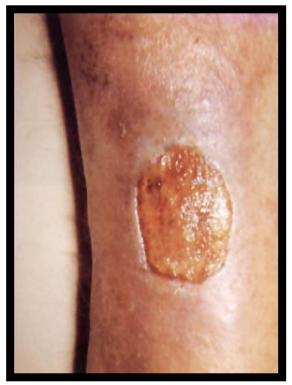
☐ Large Varicose Veins



☐ Swelling



☐ Skin Changes



☐ Venous Ulcer

Please indicate with an 'x' the location(s) of your varicose veins on the images below

Anterior Right Lateral Left Lateral Posterior

Referring Physician _____

Patient Signature _____ Date _____