Vein Care Specialists
Patient Health History Form

Name: _____ DOB: _____ Date: _____

When did your symptoms start? _____

Do you have any of the following?

☐Pain ☐Aching ☐Throbbing ☐Heaviness ☐Leg Tiredness ☐Skin discoloration
☐Bleeding ☐Ulcers/sores ☐Itching ☐Leg swelling ☐Leg cramps ☐Burning
☐Superficial vein clots ☐Restless Leg Syndrome

Do your symptoms involve one or both legs?

☐Right ☐Left ☐Both

Please rate your pain level: (circle one) 0 (none) 1(very low)-2-3-4-5-6-7-8-9-10(very high)

Have you tried over-the-counter pain medication for leg pain/discomfort? ☐No ☐Yes
If yes, type of medication _____

Do you feel your symptoms interfere with or impair any of the following? (Circle that apply)

Work	*none*	*a little*	*some*	*most of the time*	*all the time*
Housework	*none*	*a little*	*some*	*most of the time*	*all the time*
Walking	*none*	*a little*	*some*	*most of the time*	*all the time*
Sitting	*none*	*a little*	*some*	*most of the time*	*all the time*
Kneeling	*none*	*a little*	*some*	*most of the time*	*all the time*
Standing	*none*	*a little*	*some*	*most of the time*	*all the time*

Do you use compression stockings? ☐No ☐Yes Duration of use _____

Do you take any blood thinners (anticoagulation or antiplatelet medications)? ☐No ☐Yes

Do you have a personal history of DVT or other blood clots or a clotting disorder? ☐No ☐Yes

Do you have a family history of varicose veins or vein disease? ☐No ☐Yes

Have you had prior vein procedures? ☐No ☐Yes

Do you have a history of migraines with aura? ☐No ☐Yes

Do you have a history of patent foramen ovale or other heart shunts? ☐No ☐Yes
(a hole in the heart that didn't close the way it should after birth)