

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>Symptoms:</b> <i>(Please check if yes)</i>	<b>R</b>	<b>L</b>	<i>(Check if you've had any of the following)</i>
Aching/pain in legs	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease <input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease <input type="checkbox"/>
Tiredness/fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis <input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure <input type="checkbox"/>
Leg cramping	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/>
Leg restlessness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	Leg Trauma/Surgery <input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery/Hospitalizations <input type="checkbox"/>
Do your symptoms interfere with your sleep?			<i>(Please list on back, if needed)</i>
Do your symptoms interfere with walking?			
Do your symptoms worsen with or after activity?			

***On a scale of 1 to 10, with 10 being the worst, I consider my vein disease to be:***  
 Slightly bothersome    1    2    3    4    5    6    7    8    9    10    Severely affecting my life

**Conservative Measures Used Currently or Previously:** *(Please check those measures that you have tried)*  
 Pain medications or herbal supplements:     Leg elevation:     Exercise:     Job Change:   
 Compression stockings or leg wraps:     *If so, how long?* \_\_\_\_\_    Weight loss:

**RLS:** *(Please check box if yes)*

Do you find the need to move your legs to relieve an uncomfortable feeling?

Do your legs feel better when moving them or walking?

Are your leg symptoms worse when sitting or resting, without elevating legs?

Are your leg symptoms worse later in the day or night?

**Women Only:** *(Please check box if yes)*

Are you pregnant or considering a pregnancy sometime in the future?

Are you breast-feeding?     Are your legs more painful associated with menstruation?

Have you been diagnosed with Pelvic Congestion Syndrome?

Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_ Ages of Children? \_\_\_\_\_

Please list *prescription* and *OTC* medications:                      *(Use back if needed)*                      Please list Medical Allergies:

\_\_\_\_\_

\_\_\_\_\_

***Please check box if you have, or have had, any of the following:***

A prior evaluation for your veins?

Previous vein surgery or laser treatment?

Previous vein injections?

Bleeding from a vein?

A leg ulceration?                       A family history of vein disease?

Phlebitis?                                       A family history of leg ulceration?

Any type of blood clot/clotting disorder?                       A family history of blood clots?

*If so, were you treated with blood thinners?*