Venous Health History Form

Name:_____ Date:_____

Age: _____ Sex: M F

1. Have you ever had vein stripping surgery? Yes No

2. Do you experience any of the following?

a. Aching/pain in your legs? …….	Yes	No
b. Heaviness? ……	Yes	No
c. Tiredness/fatigue? …….	Yes	No
d. Itching/burning? ……	Yes	No
e. Swollen ankles? ……	Yes	No
f. Leg cramps? ……..	Yes	No
g. Restless legs? ……	Yes	No
h. Throbbing? ……	Yes	No
Other? _____	Yes	No
Do you experience these problems in just one, or both legs?	One	Both

3. Do you take any medication for pain (eg, advil, etc.)? Yes No

   If yes, what medication and how often? _____

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

5. Do you wear support hose prescribed by a doctor? Yes No

   If yes, how long have you worn them? _____

6. Do you have any problem walking? Yes No

   If yes, how does it affect you? _____

7. Do you stand much at work? Yes No
   at home? Yes No

8. Have you ever had any test (s) done on your veins? Yes No

   If yes, when, what type test and where on the leg? _____

   _____

9. Were you diagnosed with saphenous vein reflux? Yes No