Patient History

VEIN THERAPIES of Chattanooga, PLLC

Name: _____ **Age**: _____ **Date**: _____

Occupation: _____

How long have you had leg vein problems? Months_____ Years_____

Please check LEG symptoms you currently have or have experienced in the last 3 months:

☐ **No symptoms**	☐R	☐L	☐ **Aching**	☐R	☐L
☐ **Restlessness**	☐R	☐L	☐ **Heaviness**	☐R	☐L
☐ **Itching**	☐R	☐L	☐ **Burning**	☐R	☐L
☐ **Cramping**	☐R	☐L	☐ **Throbbing**	☐R	☐L
☐ **Fatigue**	☐R	☐L	☐ **Swelling**	☐R	☐L

Do your symptoms interfere with sleep? Yes No
Do they interfere with walking? Yes No

On a scale of 1-10, with 1 being *slightly bothersome* and 10 being *severely affecting my life,* I consider my vein disease to be:

1 2 3 4 5 6 7 8 9 10

Are your varicose or spider veins located in another area besides your leg? If so, where?

_____

Please check if you have /ever had:

☐ Leg ulcers	☐R	☐L	☐ Bleeding from a vein	☐R	☐L
☐ Blood clot/Phlebitis	☐R	☐L	☐ Vein Surgery	☐R	☐L
☐ Prior vein evaluation/treatment	☐R	☐L	☐ Vein Injections/Sclerotherapy	☐R	☐L
☐ Leg Injury/Trauma	☐R	☐L			

Check any of the following that are true:

☐ I have tried elevation of my legs to relieve discomfort for _____months.
☐ I have tried elastic support/compression stockings.
What type? _____ How long? _____
☐ I have tried regular exercise.
☐ Standing makes my symptoms worse.
I stand for _____ hours per day.

Please check if you have/ ever had:

□ Heart disease □ High blood Pressure □ Hepatitis □ HIV (AIDS)
□ Cancer □ Diabetes □ Bleeding disorder □ Pacemaker
□ COPD □ Stroke □ Blood clot to Lung

Do you have a family history of?
□ Heart disease □ Cancer □ Diabetes
□ Varicose veins □ Leg Ulcers □ Clotting /Bleeding disorders

Do you smoke? Y / N Packs per day ____
Do you drink alcohol? Y / N

Over the counter medications &/ or Prescription Medications:
Include Aspirin, Motrin, Tylenol, or Herbals if applicable:

_____

_____

Allergies: Medications? _____

Iodine? _____ Tape? _____ Latex? _____
Please list on back if needed.

Please list any surgeries/hospitalizations (other than vein surgeries) and dates:

For Women only: (Please check box if YES)
□ Are you pregnant or considering pregnancy in the near future?
□ Are you breastfeeding?
□ Worsening of varicose vein symptoms during pregnancy?
Number of pregnancies_____ Deliveries _____
□ Worsening of symptoms around menstrual cycle?
Do you take: □ Birth control pills? □ Estrogen replacement therapy?

Signature:_____ Date:_____