**HISTORY:**  Reason for evaluation: _______________________________________________________

Symptom onset (approximately): ____________________  Worse since: ___________________

**Symptoms include:**
- ☐ discomfort/pain/aching
- ☐ leg heaviness
- ☐ leg fatigue
- ☐ swelling
- ☐ cramping
- ☐ burning
- ☐ itching
- ☐ skin changes
- ☐ restless legs
- ☐ bleeding from a vein
  - ☐ NONE

**Symptoms worsened by:**
- ☐ standing
- ☐ menstruation
- ☐ pregnancy
- ☐ heat
- ☐ walking
- ☐ exercise
- ☐ Other ____________________  - ☐ NOTHING

**Symptoms helped by:**
- ☐ leg elevation
- ☐ compression hose
- ☐ walking
- ☐ exercise
- ☐ Other ____________________  - ☐ NOTHING

**Does your occupation or life style require prolonged:**
- ☐ standing
  - ☐ Yes
  - ☐ No
  - or
- ☐ sitting
  - ☐ Yes
  - ☐ No

**Have you ever had:**
- ☐ venous blood clots
- ☐ pulmonary embolism (blood clots to the lung)

**Lower extremity:**
- ☐ injury
- ☐ fractures
- ☐ operations
- ☐ immobilizations
- ☐ ulceration

**Have you ever had any vein evaluations or treatments?**
  - ☐ Yes
  - ☐ No

If yes:
- ☐ ultrasound exam
- ☐ surface laser treatment
- ☐ sclerotherapy
- ☐ vein surgery
- ☐ endovenous laser ablation
- ☐ endovenous radiofrequency ablation

**REVIEW OF SYSTEMS:** Check box if YES:

- ☐ fevers
- ☐ swollen lymph glands
- ☐ visual disturbances
- ☐ nosebleeds
- ☐ headaches
- ☐ migraine
- ☐ seizures
- ☐ chest pain
- ☐ heart racing
- ☐ fainting
- ☐ swollen ankles
- ☐ wheezing
- ☐ shortness of breath
- ☐ heartburn
- ☐ black or bloody stools
- ☐ blood in urine
- ☐ current pregnancy
- ☐ planned pregnancy in near future
- ☐ actively nursing
- ☐ pelvic pain
- ☐ pelvic veins
- ☐ joint pain
- ☐ low back pain
- ☐ sciatica
- ☐ anxiety
- ☐ depression
- ☐ skin rashes
- ☐ anemia

**PAST MEDICAL HISTORY:**

**Illnesses:**
- ☐ none
- ☐ severe allergies
- ☐ asthma
- ☐ hepatitis
- ☐ tuberculosis
- ☐ herpes
- ☐ HIV
- ☐ cancer

Other illnesses: __________________________________________________________________________

**Obstetrical:**
- Number of pregnancies - _____  
- Number of children - _____

**Surgeries:**
- ☐ none
- ☐ pacemaker
  
**Do you experience the formation of excess scar tissue?**
  - ☐ Yes
  - ☐ No

**Medications:**
- ☐ none
- ☐ aspirin
- ☐ anti-inflammatories
- ☐ blood thinners
- ☐ birth control pills
- ☐ hormonal replacement therapy
- ☐ Antabuse
- ☐ Minocin

Please list any other medications: __________________________________________________________

______________________________________________________________________________________

**Allergies:**
- ☐ none
- ☐ adhesive tape
- ☐ latex
  
**Do you get lightheaded or faint from needles or medical procedures?**
  - ☐ Yes
  - ☐ No

**Have you ever had a bad reaction to a local anesthetic or a sedative?**
  - ☐ Yes
  - ☐ No

**PERSONAL AND SOCIAL HISTORY:**
Marital status:  □ Single □ Married □ Other__________

Occupation: ____________________________________________ □ retired

Do you exercise regularly?  □ Yes □ No  If yes, preferred exercise ______________________

Do you smoke?   □ Yes □ No   If yes, ______ packs per day

Level of daily activity:  □ active □ limited activity □ sedentary □ walker or cane or wheelchair

FAMILY HISTORY:

Is there a family history of vein disease?  □ Yes □ No   If yes, □ varicose veins □ spider veins □ venous blood clots □ deep vein thrombosis (DVT) □ pulmonary embolism □ blood clotting disorder

Signature: ____________________________________________ Date: _____/_____/______