East Tennessee
VEIN CLINIC

Patient History

Name: _____ **Date:** _____/____/_____ **Age:** _____

Pharmacy: _____ **Address:** _____ **Phone #:** _____

Please check leg symptoms you currently have or have experienced in the past 3 months:
(✓-check at appropriate line)

	Right	Left
no symptoms	_	_
aching	_	_
restlessness	_	_
heaviness	_	_
itching	_	_
burning	_	_
cramping	_	_
throbbing	_	_
fatigue	_	_
swelling	_	_
other:_____	_	_

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:

	Right	Left
_leg ulcers	_	_
_bleeding from a vein	_	_
_blood clot/phlebitis	_	_
_vein surgery	_	_
_prior vein evaluation/treatment	_	_
_vein injections	_	_
_leg injury/trauma	_	_

_heart disease _ high blood pressure
_hepatitis _HIV *(AIDS)*
_cancer _diabetes
_migraine

Do you have a family history of?
_heart disease -leg ulcers _diabetes
_varicose veins _clotting disorders

Do you have any medical problems that you see a Specialist? If yes, list the medical problem and Physician Name: _____

_____

Do You Smoke? __Y / __N If Yes, # Packs per day._____
Do You Drink Alcohol? __Y / __N

OTC Medications/Prescription	Allergies

(Please list on back, if more space is needed

Please check Yes or No:
I have tried elevation of my legs to relieve discomfort for _____ months. _-Yes _-No
I have tried elastic support/compression stockings. _-Yes _-No
If Yes: What type? How long?

_____

I have taken medication for my leg symptoms. _-Yes _-No
If Yes: What medication? How long?

_____

Standing makes my symptoms worse. _-Yes _-No
I stand _____ hrs. per day.

Please list any surgeries/hospitalizations *(other than vein surgeries)* and month/year:

_____

_____

Please list your occupation:_____

For Women only:
Are you pregnant or considering pregnancy in the near future? _-Yes _-No
Are you breastfeeding? _-Yes _-No
Worsening of symptoms during pregnancy? _-Yes _-No
Worsening of symptoms around menstrual cycle? _-Yes _-No
Number of pregnancies? _____. Deliveries?_____
Do you use birth control pills or take estrogen replacement therapy? _-Yes _-No

Signature:

_____