

Varicose Vein Consult Form

Patient Name: _____ Date of Birth: _____

1. Have you ever had vein stripping surgery? YES NO

If yes, when and which leg? _____

2. Have you ever had vein injections? YES NO

If yes, When, Which leg? _____

3. Have you ever had a blood clot? YES NO

If yes when, which leg? _____

4. Have you ever had phlebitis? YES NO

If yes, which leg and when? _____

5. Have your veins gotten progressively worse? YES NO

6. Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs? If yes, who? _____

7. Do you experience any of the following in your legs? (Please circle)

Aching /pain

Swollen ankles

Restless legs

Heaviness

Legs cramps

Throbbing

Tiredness/fatigue

Itching /Burning

Other

8. Do you take any medication for pain (Advil, Motrin)? YES NO

If yes, what medication and how often? _____

9. Do you elevate your legs to relieve discomfort? YES NO

If yes, does it provide relief? _____

10. Do you exercise? YES NO

If yes, what type and how often? _____

11. Do you wear prescription compression stockings? YES NO

If yes, what type, how long have you worn and who prescribed?

12. Have you ever had any test(s) done on your veins? YES NO

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

13. Were you diagnosed with saphenous vein reflux? YES NO

Patient Signature: **X** _____ Date: _____