COMMUNITY Vein CARE

Name_____ Date of Birth_____

Allergies_____ Current Medications_____

Previous Surgeries (including vein treatments)_____

Past Medical Conditions_____

Occupation_____

Why are you seeking treatment for your veins?_____

Do your daily activities require prolonged periods of standing? Yes___ No___

If yes, how many times a day do you have to sit or take a break due to symptoms in your lower extremities? (circle one)

Never Once per day 2-3times per day 4 or more times per day

Are there any activities that you cannot perform due to pain in your legs? Yes___ No___

If yes, what are they?_____

How long have you had the veins you are concerned about?_____

What aggravates your veins?_____

Do you have a history of the following (circle all that apply)?

Ulcerations Chronic swelling Blood clots

Do you take over-the-counter-medications (such as aspirin or ibuprofen) or prescription medications for symptoms in your lower extremities? Yes___ No___

If yes, how many days in a two week period do you take the medication? (circle one)

0-2 days 3-4 days 5-6 days 7 or more days

Please complete other side

Do you have a family history of varicose/spider veins? Yes___ No___

Relationship(s)_____

Please check all that apply:

Symptom	**Right Leg**	**Left Leg**
Edema (swelling)		
Pain (mild, moderate, severe)		
Tiredness, throbbing, achiness		
Ulceration		
Skin color changes		
Spider veins		
Varicose veins		

Do you, or have you, ever worn compression stockings? Yes___ No___

If yes, how long have you worn them?_____

If yes, do the stockings significantly improve your symptoms? Yes ___ No___

How did you hear about us?_____

Primary Care Physician (name, address, phone)_____

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