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VARICOSE VEIN HISTORY

DATE: _____

PATIENT NAME: _____

CIRCLE ALL THAT APPLY

1/ Leg symptoms:

☐ aches ☐ heaviness ☐ cramping ☐ leg fatigue
☐ burning ☐ bleeding ☐ sharp pain ☐ itching
☐ throbbing ☐ swelling ☐ leg cramps ☐ ulceration
☐ restless legs

2/ Prior history of:

☐ thrombophlebitis ☐ venous ulcers ☐ leg clots (DVT)

3/ Symptoms occur at rest ☐ Symptoms are with daily activities ☐ Symptoms are only with major exertion ☐

4/ Symptoms worse with: ☐ sitting ☐ standing ☐ walking ☐ at night

5/ Prior conservative management attempted:

☐ leg elevation ☐ pain medications ☐ walking program

6 ☐ I Have ☐ Have Not tried elastic compression stockings
if yes, for how long:
on which leg: R ☐ L ☐ both ☐

7/ Prior invasive management:
Surgery: stripping: R ☐ L ☐ ligation: R ☐ L ☐
Sclerotherapy/Injections: R ☐ L ☐
Laser: ☐ or L ☐

8/ Prior problems with anesthesia: Y ☐ N ☐