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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 or L or both

7/ Prior invasive management:

Surgery: stripping: R or L ligation: R or L
Sclerotherapy/Injections: R or L
Laser: R or L

8/ Prior problems with anesthesia: Y or N