NORTHWEST
Vein & Aesthetic Center
4700 Point Fosdick Dr. NW, Suite 307 Gig Harbor, WA 98335
253-857-8346 (VEIN) www.nwveins.com

VENOUS HISTORY

PATIENT NAME: _____ **DATE:**_____

Please check if you have had any of the following:

☐ Bleeding Disorder ☐ Deep Venous Thrombosis ☐ HIV ☐ MRSA
☐ Pulmonary Embolism ☐ Superficial Phlebitis ☐ Hepatitis

Are you pregnant or nursing? **YES** **NO** **N/A**

DO YOU HAVE .... (Please check):

☐Aching or throbbing ☐Ankle/leg swelling ☐Skin changes ☐Hard lumps
☐Tired/Heavy legs ☐Leg pain ☐Ulcers or ulceration ☐Spider veins
☐Burning pain in leg ☐Tenderness ☐Red/warm areas ☐Facial veins
☐Night cramps ☐Varicose veins (bulging) ☐Itching ☐Other:_____

PERSONAL HISTORY OF VARICOSE VEINS OR SPIDER VEINS:

How many years have you had trouble with your veins? _____

- Related to pregnancy **YES NO**
- Related to accident/trauma **YES NO**
- Are you developing new veins? **YES NO**

Are your symptoms worse with:

Prolonged standing **YES NO**
Prolonged sitting **YES NO**
Menstrual cycle **YES NO**

How does your discomfort/leg pain interfere with your daily living?

☐Cleaning ☐Working ☐Driving ☐ Meal Preparation
☐Household Chores ☐Sleeping ☐Gardening ☐ Taking care of kids
☐Walking ☐Bathing ☐Sitting
☐Running/Exercise ☐Standing

☐Other:_____

- Are your symptoms relieved with rest/elevation of leg(s)? **YES NO**
- Do you need to stop to elevate your legs throughout the day? **YES NO**
- Do your symptoms require you to make accommodations at work? **YES NO**
- Do you feel the need to sit after standing for a short period of time? **YES NO**

FAMILY HISTORY OF VARICOSE VEINS OR SPIDER VEINS:

☐Mother ☐Father ☐Brother ☐Sister ☐Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐None

PREVIOUS CONSERVATIVE TREATMENT YOU HAVE TRIED:

Have you ever worn compression stockings for your veins? **YES** **NO**
When? _____ How Long? _____
How did they affect your symptoms (leg pain/swelling)?
Completely helped _____ Partially helped _____ Didn't help_____
Do you take pain medications (Advil, Tylenol) for your leg pain/veins? **YES** **NO**

PREVIOUS TREATMENT HISTORY:

Ligation/Stripping surgery **YES** **NO** If so, which leg? _____ When? _____
Injection treatments **YES** **NO** If so, which leg? _____ When? _____
Laser therapy **YES** **NO** If so, which leg? _____ When? _____
Other: _____

Patient Signature: _____**Date:** _____

Provider Signature:_____ **Date:** _____