



NAME: _____ AGE: _____ DATE: _____

SYMPTOMS: (Please check those that apply to you.)

	Left	Right		
Aching/Pain	<input type="checkbox"/>	<input type="checkbox"/>	My symptoms interfere with sleep.	<input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	My symptoms interfere with daily activities.	<input type="checkbox"/>
Tiredness/Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	My symptoms interfere with walking.	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	My legs feel best in the morning.	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	I have had blood clots or phlebitis.	<input type="checkbox"/>
Cramps/Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	I have had leg ulcers.	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	I have had bleeding from my veins.	<input type="checkbox"/>

On a scale of 1 to 10, with 10 being the worst, I consider my veins to be:
 Slightly bothersome 1 2 3 4 5 6 7 8 9 10 Severely affecting my life

CONSERVATIVE MEASURES: (Please check those that apply to you.)

- I have tried elevating my legs to relieve the discomfort.
- I have tried Tylenol, Ibuprofen, Advil, or Aleve to help with my leg pain.
- I have tried compression stockings or wraps to help improve my symptoms.

Current Medications: (Including Vitamins, Herbals, and other OTC's.)

Medication Allergies:

Vein History: (Please check if true.)

- I have had prior vein evaluations.
- I have had prior vein surgery.
- I have had prior vein injections.
- Family history of vein disease.
- Family history of blood clots.

General Medical History: (Please check if true.)

- I have Hepatitis or HIV.
- I have heart disease.
- I have cancer.
- I have had major surgery or hospitalizations:

Women's Health History:

- I am pregnant, breast-feeding, or trying to become pregnant.
- I am over the age 35, take birth control, and occasionally smoke.
- Number of pregnancies? _____ Number of deliveries? _____

What things do you hope treatment will accomplish? (Please list in the order of importance to you.)

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____