Vein Medical Questionnaire

Name: ______________________________ Date: ______________

Date of Birth: ______________ Sex: Male / Female

Please answer the following questions:

Past Medical and Surgical History

1. Have you ever been in the hospital as a patient? Yes No

   If yes, for what reason: ______________________________

2. Have you ever had surgery? Yes No

   If yes, what type of surgery and when: ______________________________

3. Are you presently under the care of a physician? Yes No

   If yes, for what illness or purpose: ______________________________

4. Do you have any of the following:

Heart disease	Yes	No
Lung disease	Yes	No
Hepatitis	Yes	No
Arthritis	Yes	No
Leg ulcers	Yes	No
Diabetes	Yes	No

Child Rearing History

1.	Are you currently pregnant or think you may be pregnant?	Yes	No
2.	How many times have you been pregnant?	Yes	No
3.	Do you intend on becoming pregnant again?	Yes	No
4.	Are you currently breastfeeding?	Yes	No

Family History

1. Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs (indicate who below)?

Father	Yes	No
Mother	Yes	No
Brother(s)	Yes	No
Sister(s)	Yes	No
Other (list): ______________	Yes	No

Current Medical History

1. Do you have any allergies *(medication, latex, iodine or x-ray dye, food/shellfish, environmental, etc.)*? Yes No

   If yes, list them and briefly describe your reaction *(e.g. rash, hives, shortness of breath, etc)*:

2. Are you presently taking any medication *(including prescription [blood thinners, hormones, birth control pills], over-the-counter, vitamins, herbal, etc.)*? Yes No

   If yes, list them: ______________________________

3. Do you smoke? Yes No

   If yes, how many packs per day? ______________________________

Current Venous History

1. Have you ever had a blood clot/deep vein thrombosis (DVT)? Yes No

   If yes, which leg and when? ______________________________

2. Have you ever had phlebitis? Yes No

   If yes, which leg and when? ______________________________

3. Have you ever had vein stripping surgery? Yes No

   If yes, which leg and when? ______________________________

4. Have you ever had vein injections? Yes No

   If yes, which leg, where on the leg, and when? ______________________________

   ____

5. Do you experience any of the following (check all that apply)?

	Right Leg	Left Leg
Aching/pain in your leg(s)	☐	☐
Heaviness	☐	☐
Tiredness/fatigue	☐	☐
Itching/burning	☐	☐
Swollen ankle(s)	☐	☐
Leg cramps	☐	☐
Restless leg(s)	☐	☐
Throbbing	☐	☐
Other (list):	☐	☐

6. Have your veins gotten worse in recent months? Yes No
7. Do you elevate your legs to relieve your symptoms/discomfort? Yes No
8. Do you wear support hose prescribed by a physician? Yes No

   If yes, what type? ______________________________

9. Do you wear light support hose (e.g. Sheer Energy)? Yes No
10. Do your support hose provide relief? Yes No
11. Do you have problems walking? Yes No

    If yes, how does it affect you? ______________________________

12. Do you stand much at work? Yes No

    at home? Yes No

13. How does this standing affect your legs (describe)?

    ____

14. Have you ever had your veins evaluated before? Yes No

    If yes, when and where? ______________________________

15. Have you ever had any test(s) done on your veins? Yes No

    If, yes, what test(s) and when? ______________________________

    Results? ______________________________

______________________________ ______________

Patient Signature *Date*

______________________________ ______________

Signature of LIP or RN Reviewing *Date*