THE IOWA CLINIC®

vein therapy center

Vascular Surgeons
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VARICOSE VEIN HISTORY

Name ______________________________ Date of birth ______________

How many years have you had varicose veins? ________ Spider veins?______________

LEG SYMPTOMS

(Please circle all that apply. Indicate right and/or left leg.)

Itching	R	L
Leg cramps at night	R	L
Restless legs	R	L
Swelling in ankles/calves	R	L
Achy legs	R	L
Tired/fatigued legs	R	L
Heaviness in legs	R	L
Skin ulcers	R	L
Bleeding veins	R	L
Throbbing legs	R	L
Burning legs	R	L
Increasing leg pain	R	L

Rate your pain on a scale from 1-10 *(10 highest)*

____

List any other symptoms

____

____

____

If you have been pregnant:
Number of times ____ Number of children ____

Do you elevate your legs? ❏ Yes ❏ No

Do you regularly exercise? ❏ Yes ❏ No
If yes, what type(s) of exercise?

____

Have you worn compression stockings in the past year? ❏ Yes ❏ No
If yes, how long have you have you worn them?

____

Do your leg symptoms effect your activity of daily living? ❏ Yes ❏ No

MEDICATION ALLERGIES

(Please list name of medication and adverse reaction.)

____

____

____

CURRENT MEDICATIONS

(Please list all medications, dosages and frequency.)
(Example: Metoprolol 50mg 2 times a day)

____

____

____

____

____

____

REVIEW OF SYSTEMS

(Please check all that apply.)

- ❏ Recent weight loss *(past 6 months)* _______ lbs
- ❏ Frequent constipation
- ❏ Feeling tired/fatigued
- ❏ Skin rash
- ❏ Frequent dizziness
- ❏ Muscle cramps at night
- ❏ Vision problems
- ❏ Bleed easily
- ❏ Skin wound slow to heal
- ❏ Swelling in legs or ankle R L
- ❏ Frequent headaches
- ❏ Difficulty breathing/shortness of breath
- ❏ Chest pain/discomfort

OVER >

PAST MEDICAL HISTORY

(Please check all that apply.)

History of:

- ❑ Blood clot of the deep veins of the legs (DVT)
  What year(s)? _________ R L
- ❑ Blood clot of the superficial veins of the leg (Phlebitis)
  What year(s)? _________ R L
- ❑ High blood pressure
- ❑ Coronary artery disease
- ❑ Peripheral vascular disease
- ❑ Chronic obstructive pulmonary disease (COPD)
- ❑ Diabetes mellitus

PAST SURGICAL HISTORY

(Please check all that apply.)

History of:

Varicose vein procedures:

- ❑ Ligation (tying off of vein)
  What year(s)? _________ R L
  Doctor________________
- ❑ Ligation with stripping
  What year(s)? _________ R L
  Doctor________________
- ❑ Sclerotherapy (injection)
  What year(s)? _________ R L
  Doctor________________
- ❑ Venous Ablation
  What year(s)? _________ R L
  Doctor________________

Please list other surgeries here:

____

____

____

____

FAMILY HISTORY

(Please circle all that apply.)

Family (Father, Mother, Brother, Sister)
History of:

Adverse reaction to anesthesia	F	M	B	S
Type of reaction ______________________				
Aortic aneurysm	F	M	B	S
Cancer	F	M	B	S
Diabetes mellitus	F	M	B	S
Heart disease	F	M	B	S
Bleeding problems	F	M	B	S
High blood pressure	F	M	B	S
Stroke	F	M	B	S
Blood clots	F	M	B	S
Varicose veins	F	M	B	S

PERSONAL HISTORY

Do you use tobacco products?
❑ Yes ❑ No ❑ Never

(If yes, please check all that apply)
❑ Cigarettes ❑ Chewing tobacco
❑ Cigars ❑ Electronic cigarettes

If no, did you previously smoke? ❑ Yes ❑ No
If yes, when did you quit?__________________

Do you drink caffeinated beverages?
❑ Yes ❑ No

(If yes, please check all that apply)
❑ Coffee ❑ Tea
❑ Soda/pop

How many cups/bottles per day?
____

Do you drink alcohol? ❑ Yes ❑ No

Please bring the completed history form with you to your appointment. Thank you.