



PATIENT NAME: _____ CHART NUMBER: _____ DATE: _____

Who is your primary care doctor? _____

Who referred you to us? _____

In just a few words, what is the main problem with your legs/veins?

Circle **ALL** of the following symptoms that you experience.

- Pain aching heaviness tiredness fatigue itching burning
- Stinging cramping restlessness throbbing numbness stabbing
- swelling skin discoloration weeping fluid bleeding from veins
- sores or wounds on your legs that won't heal normally

Circle which leg? Both Right Left

Circle how bad it gets on a scale of 0 to 10 (0=no symptoms 10=worst imaginable)

Right	0	1	2	3	4	5	6	7	8	9	10
Left	0	1	2	3	4	5	6	7	8	9	10

Circle how long the symptoms have been going on?
< 6 months, > 6 months, more than a year, more than 5 years, more than 10 yrs, decades

Circle everything that makes the symptoms get worse?
Standing sitting walking lying down elevating legs/feet
Other _____

Check **EVERYTHING** you do to help relieve the symptoms?

- _____ Sit down ___ lie down ___ prop your feet or legs up
How often? ___once/day ___more than twice a day
- _____ Take over the counter medications like Tylenol, Advil, or Aleve
How often? ___ Less than 5 times in 2 weeks ___ more than 5 times in 2 weeks
- _____ Take prescription medications
What? ___Pain meds ___muscle relaxants ___restless leg meds ___ arthritis
- _____ Use ice packs or a heating pad _____ Use creams or ointments like Ben-Gay, Icy Hot?

MD Signature _____ Date _____



____ Wear graduated compression garments
For how long? ____ less than 3 months ____ more than 3 months

Describe how these symptoms bother you at work or interfere with your job duties?

Circle the times when your legs hurt, annoy, bother, distract, disrupt, disturb or decrease your quality of life:

- Showering brushing teeth shaving putting on make-up fixing hair
- Vacuuming dusting mopping washing dishes cooking doing laundry
- Ironing folding clothes taking out trash getting the mail walking the dog
- Shopping grocery shopping doing yard work gardening household chores
- Washing car cutting grass raking leaves trimming bushes sweeping patio or driveway
- Using weed trimmer or leaf blower playing with children or grandchildren
- Sitting through church service sitting at the movies sitting through sporting events
- Going out to dinner driving or riding in a car or plane
- Other _____

Check any of the following problems a doctor has diagnosed you with.

- ____ Deep vein thrombosis (DVT) - blood clot in deep veins of legs (usually treated with blood thinner)
- ____ Superficial thrombophlebitis- blood clot in superficial veins of leg
- ____ Pulmonary Embolus (PE)- blood clot that moved to or found in the lung
- ____ A blood clotting problem (like Antithrombin III, Protein C, Protein S deficiency, Factor V mutation, Lupus Anticoagulant)
- ____ A bleeding problem (like Hemophilia, Von Willebrand's, Factor VIII deficiency)
- ____ Congestive heart failure, ____ kidney failure

What other medical problems do you have?

MD Signature _____ Date _____



Check prior vein treatments or vein surgery you have had? None
 Vein Stripping, Ambulatory Phlebectomy, Sclerotherapy, Closure, EVLT,
 Leg vein removal for heart or vascular bypass
Who? _____ Where? _____

What other operations have you had?

Circle conditions your family members have:
Varicose veins, venous ulcers, DVT, Phlebitis, Pulmonary embolus, clotting or bleeding disorder

What other medical conditions do your family members have?

What medications, supplements, or vitamins do you take?

Are you allergic to anything?

Height: _____ Weight: _____

Do you use tobacco? yes no

Do you drink alcohol? yes no

MD Signature _____ Date _____