VITA
Vascular Interventional of Thomasville, Associates

Patient Venous History

Patient Name: _____ Date of Birth: _____

Please circle or fill in the appropriate answer for each question in ALL sections.

General

Have you had any previous vein procedures? *Vein Stripping* *Vein Ablation (laser)* *Vein Injections*

If yes, when? _____

Do you have any history of Deep Vein Thrombosis(clot) or Superficial Vein Thrombosis(clot)? *Yes* *No*

Do you have a history of ulcers (wounds or sores)? *Yes* *No* If yes, are the ulcers currently Active *or Healed*

Do you have a history of bleeding veins? *Yes* *No*

Do you have any dark discoloration on your lower legs? *Yes* *No*

If yes, how long have you had the discoloration? _____years _____months

Do you currently wear compression hose? *Yes* *No* Are they prescription or over the counter? _____

What are your goals of treatment? *Relief of Pain* *Relief of Swelling* *Cosmetic Improvement*

Right Leg

Pain

Is there pain in your **right** leg? *Yes or No*

Please circle level of pain on a scale of 1-10: *1 2 3 4 5 6 7 8 9 10*

Please circle the location of the pain: *Thigh* *Calf* *Foot* Other: _____

Please circle the description of the pain: *Heavy* *Achy* *Throbbing* *Sharp* Other: _____

Is the pain worse with sitting? *Yes or No* Is the pain worse with standing? *Yes or No*

Is the pain worse in the evenings and/or afternoons? *Yes or No*

How long have you had this symptom? _____ years _____months

Is the pain improved with: *Leg elevation* *Pain meds* *Compression* *Neither*

Does this pain occur daily? *Yes or No*

Swelling- RIGHT LEG

Where is, the swelling located? _____

Is the swelling: *Mild* *Moderate* *Severe*

How long have you had this symptom? _____ years _____months

Are you on any diuretics (water pills)? *Yes or No* If yes, what kind? _____

Left Leg

Pain

Is there pain in your **left** leg? *Yes or No*

Please circle level of pain on a scale of 1-10: *1 2 3 4 5 6 7 8 9 10*

Please circle the location of the pain: *Thigh* *Calf* *Foot* Other: _____

Please circle the description of the pain: *Heavy* *Achy* *Throbbing* *Sharp* Other: _____

Is the pain worse with sitting? *Yes or No* Is the pain worse with standing? *Yes or No*

Is the pain worse in the evenings and/or afternoons? *Yes or No*

How long have you had this symptom? _____ years _____months

Is the pain improved with: *Leg elevation* *Pain meds* *Compression* *Neither*

Does this pain occur daily? *Yes or No*

Swelling-LEFT LEG

Where is, the swelling located? _____

Is the swelling: *Mild* *Moderate* *Severe*

How long have you had this symptom? _____ years _____months

Are you on any diuretics (water pills)? *Yes or No* If yes, what kind? _____

GENERAL

How do your symptoms affect your Activities of Daily Living (ADL)?

a. Can't Exercise
b. Can't Shop
c. Can't go to social events
d. Miss Work
e. Chronic Pain, causing mood changes (depression)
f. Loss of sleep
g. Can't get shoes on
h. Difficulty Walking
i. Other: _____