

# Great Lakes Comprehensive Vein Specialists

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## PATIENT VENOUS MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Please state all allergies: \_\_\_\_\_

Please list all medications: \_\_\_\_\_

Please circle below any of the medical conditions that you have:

High Blood Pressure   Cancer   Heart Disease   Diabetes   Lung Disease   Liver Disease   Asthma

Please list any other medical conditions: \_\_\_\_\_

Please list any previous surgeries and dates: \_\_\_\_\_

### Venous Symptoms and History

1) Have you had any prior treatment for varicose veins/spider veins? YES  NO

If yes, dates of treatment and agent used (if known): \_\_\_\_\_

2) How long have you had the veins that concern you? \_\_\_\_\_

4) Do you have a family history of varicose veins/spider veins? YES  NO

If yes, relationship to you: \_\_\_\_\_

5) Are you now or have you ever been on any hormone therapy or birth control pills? YES  NO

If yes, please list: \_\_\_\_\_

6) Have you had any pregnancies? YES  NO  If yes, how many? \_\_\_\_\_

7) Are you currently pregnant or breast feeding? YES  NO

7) Does your employment require you to be standing or sitting for long periods of time? YES  NO

8) Are your veins getting worse? YES  NO

9) Do you have now or have you ever had: (Please check all that apply – If you are unsure, leave blank)

Signs and Symptoms	Right Leg	Left Leg
Pain, aching, or cramping		
Itching or burning		
Swelling		
Tiredness/leg fatigue		
Ulceration or non-healing wound		
Skin Color Changes (brown or red rashy area)		
Bleeding from leg vein		
DVT (major clot in leg)		
Superficial phlebitis (small clot in leg)		
Varicose Veins		
Spider Veins		

Conservative Therapy

Most insurance companies require a minimum of three months of “conservative therapy” which fails to provide relief prior to paying for surgical treatment. Listed below are questions about conservative therapy you should have already tried or may need to try before having surgery.

- 1) Do you wear or have you ever worn support hose? YES  NO   
 If yes, which kind?  Prescription  Over the counter  
 If yes, how long have you been wearing them? \_\_\_\_ months OR \_\_\_\_ years
- 2) Do you take pain medication for your varicose or spider veins such as aspirin, Tylenol, Ibuprofen, Aleve, etc.? YES  NO  If yes, what do you take? \_\_\_\_\_
- 3) Do you elevate your legs to relieve your symptoms? YES  NO
- 4) Do you exercise regularly? YES  NO  How many times per week? \_\_\_\_\_
- 5) Have you tried losing weight? YES  NO  NOT NEEDED
- 6) Have you altered your daily activities to avoid long periods of time where you are sitting or standing in one position? YES  NO
- 7) **Have any of these “conservative therapies” provided relief of your symptoms?**  
 YES  NO  Comments: \_\_\_\_\_

**All of the above information is accurate to the best of my knowledge.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Stops Here!**

**\* Remainder to be Filled Out By Clinical Staff \***

On Examination, Patient Has:

**Spider Veins Involving:**

<b>RIGHT</b>				<b>LEFT</b>			
Anterior Thigh	<input type="checkbox"/>	Lateral Thigh	<input type="checkbox"/>	Anterior Thigh	<input type="checkbox"/>	Lateral Thigh	<input type="checkbox"/>
Posterior Thigh	<input type="checkbox"/>	Posterior Calf	<input type="checkbox"/>	Posterior Thigh	<input type="checkbox"/>	Posterior Calf	<input type="checkbox"/>
Medial Knee	<input type="checkbox"/>	Anterior Shin	<input type="checkbox"/>	Medial Knee	<input type="checkbox"/>	Anterior Shin	<input type="checkbox"/>

**Varicose Veins Involving:**

<b>RIGHT</b>				<b>LEFT</b>			
Anterior Thigh	<input type="checkbox"/>	Lateral Thigh	<input type="checkbox"/>	Anterior Thigh	<input type="checkbox"/>	Lateral Thigh	<input type="checkbox"/>
Posterior Thigh	<input type="checkbox"/>	Posterior Calf	<input type="checkbox"/>	Posterior Thigh	<input type="checkbox"/>	Posterior Calf	<input type="checkbox"/>
Medial Knee	<input type="checkbox"/>	Anterior Shin	<input type="checkbox"/>	Medial Knee	<input type="checkbox"/>	Anterior Shin	<input type="checkbox"/>

Any Additional Notes: \_\_\_\_\_

Clinical Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_