



Venous History Worksheet

Patient Name: _____ MR#: _____ Date: _____

What is the reason for your visit today? _____

How long have you had this problem? _____ Years _____ Months

Please check which symptoms you currently have or have had:

- Leg Pain Tiredness/fatigue Tenderness Ankle Swelling
- Itching Aching/Throbbing Burning Stinging
- Leg Cramps Open Sore/Ulcer Red Warm Areas Restless Legs
- Heaviness None Other: _____

How would you rate your symptoms? (circle one)

0 1 2 3 4 5 6 7 8 9 10
 None Mild Moderate Severe Excruciating

Have your symptoms/veins gotten worse in recent months? Yes No

Describe: _____

Are your symptoms worse with any of the following?

- Prolonged sitting/standing Yes No At home? At work? _____
- Hot Baths/Heat Yes No
- Menstrual Cycle Yes No

Which of the following have you tried to treat your leg symptoms:

1. Medication (i.e. Advil, Motrin) Yes No
 If yes, name and strength: _____ How often? _____
2. Elevation of legs Yes No
 If yes, how long? _____ How often? _____
3. Wear support hose Yes No
 If yes, what type? _____ For how long? _____
4. Avoidance of any activities which make symptoms worse (i.e. hot baths, saunas) Yes No
 If yes, what? _____
5. Exercise Yes No
 If yes, what type? _____ How often? _____
6. Weight reduction Yes No
 If yes, many pounds (lbs)? _____

How do your symptoms alter your daily activities at work/home? _____

How do your symptoms alter your leisure activities such as sports, hobbies, social life, family? _____

Have you seen any physician in the past for your veins? Yes No

If yes, explain: _____

Can we contact the doctor(s) for your records? Yes* No

(i.e. prescription for compression hose, office notes from PCP, OB/GYN, surgeon, etc.)

* If yes, please fill out Authorization for Release of Medical Records form

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____