MISSOULA SURGICAL ASSOCIATES PLLC
VEIN HEALTH HISTORY FORM

Patient Name:____ **today's date**:___________________

Sex: Male_____ Female _____ Height _____ Weight _____ Shoe Size _____

Are you consulting for: Medical Reasons _____ Cosmetic Purposes _____ Both _____

How long have you noticed this problem? ____

Have you ever been treated for this problem? Yes _____ No _____

If yes, by whom? ____

By what method? Radio frequency ablation _____ Laser _____ Injections _____ Surgery ________

Have you ever been treated for the following: Phlebitis _____ Leg/Foot ulcers _____ Leg fractures/Trauma _____

Pulmonary embolism/blood clots _______ Comments:____

Are you developing new veins? Yes _____ No _____ Are your present veins getting bigger? Yes _____ No _____

At what age did your veins occur? _______

Were they associated with pregnancy? Yes _____ No _____

If yes, was it: Before______ During _____

After taking birth control or estrogen therapy? Yes _____ No _____ Other _____

If other, please explain:____

____

Please indicate any of the following symptoms/problems you have experienced: (Please circle which leg)

Pain in lower limbs?	Right Leg	Left Leg	How long?______________________
Pain in thigh?	Right Leg	Left Leg	How long? ______________________
Pain in calf?	Right Leg	Left Leg	How long? ______________________
Pain in foot?	Right Leg	Left Leg	How long? ______________________
Swelling of legs?	Right Leg	Left Leg	How long? ______________________
Skin changes/problems?	Right Leg	Left Leg	How long? ______________________
Ulcerations?	Right Leg	Left Leg	How long? ______________________
Other?	Right Leg	Left Leg	How long? ______________________

If other, please explain: ____

____

If you experience pain in your lower limbs: Is the pain exacerbated or worsened by: (check all that apply)

Extended periods of walking _____ Heat _____ Menstrual periods _____

Exercise and/or walking _____ Medications _____ Other/please explain ____________________________

____

____

Please indicate what type of pain you have:

Resting pain _____ Resting cramps _____ Burning sensation _____ Night Cramps _____

Tiredness _____ Numbness _____ Heaviness in legs _____

Does your employment require: Prolonged standing? Yes _____ No _____ Prolonged sitting? Yes _____ No _____

Is the pain alleviated by: Elevation of limbs? Yes _____ No_____ Walking and/or exercise? Yes _____ No _____

Compression stockings? Yes _____ No _____

Do you wear/have you worn elastic support/compression stockings? Yes _____ No _____

If yes, what kind and length of use: ____

Are you pregnant or planning a pregnancy? Yes _____ No _____

Do you exercise? Yes _____ No _____ If yes, how often? ____

Do you have a family history of the following?

Varicose Veins Yes _____ No _____ Relationship ____

Phlebitis (inflammation of the veins) Yes _____ No _____ Relationship ____

Blood Clots Yes _____ No _____ Relationship ____

Leg ulcers Yes _____ No _____ Relationship ____

Do you have a history of the following: Bleeding disorders _____ Bruises easily _____ Thrombophlebitis _____

Deep Vein Thrombosis _____ HIV _____ Dark spots after pregnancy, skin injury or surgery _____

SIGNATURE OF PATIENT ____***DATE*** ___________________

SIGNATURE OF PHYSICIAN ____***DATE*** ___________________