York Surgical Associates
2114 N Lincoln Ave, Suite B
York, NE 68467

A. Venous Health History Form

Patient please complete questions 1-12

Patient Name: _____ **Date of Birth:** _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

1. Do you experience any of the following in your legs?

Aching/pain?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Heaviness?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Tiredness/fatigue?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Itching/burning?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Swollen ankles?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Leg cramps?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Restless legs?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs
Throbbing?	☐ Yes	☐ No	☐ LT / RT leg	☐ Both legs

   Other?_____

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____
3. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication do you take and how many times/mgs per day? _____
   _____
4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief? _____
   _____

Venous Health History Form (cont.)

5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
   If yes, what type and gradient? How long have you worn them? _____
   _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)? ☐ Yes ☐ No
   If yes, do they provide relief? ☐ Yes ☐ No

8. Do you have any problem walking? ☐ Yes ☐ No
   If yes, describe how it interferes with your activities of daily living, which activities? _____
   _____

9. What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: _____
   _____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
    If yes, when and what type of test and where on the leg? _____
    _____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?
    _____

Patient Signature: _____Date:_____