



VIRGINIA VASCULAR CENTER

HEALTH HISTORY

Name: _____

Date: _____

Directions: Please answer the following questions, trying not to leave any blank spaces.

Past Medical History

- 1. Are you presently under the care of a physician? Yes No
If yes, for what reason?
2. Do you have: Heart Disease Yes No
Lung Disease Yes No
High Blood Pressure Yes No
Hepatitis Yes No
HIV/AIDS Yes No
Arthritis Yes No
Leg Ulcers Yes No
3. Have you ever had a blood clot (deep vein thrombosis)? Yes No
If yes, which leg and when?
4. Have you ever had phlebitis (inflammation of a vein)? Yes No
If yes, which leg and when?

Child Bearing History

- 5. Do you think you are presently pregnant? Yes No
6. How many times have you been pregnant?
7. Do you intend to have any more children? Yes No
8. Are you presently breastfeeding? Yes No

Family History

Please circle the appropriate answer.

- 9. Does anyone in your family 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

10. Do you experience any of the following?

Aching/pain in your legs?	Yes	No
Heaviness	Yes	No
Tiredness/fatigue	Yes	No
Itching/burning	Yes	No
Swollen ankles	Yes	No
Leg cramps	Yes	No
Restless legs	Yes	No
Throbbing	Yes	No
Other _____		

11. Have your veins gotten worse in recent months? Yes No

12. Do you have any problem walking? Yes No
If yes, how does it affect you? _____

13. Do you stand much at work? Yes No
at home? Yes No

14. How does this standing affect your legs? _____

15. Do you elevate your legs to relieve discomfort? Yes No

16. Do you wear support hose prescribed by a doctor? Yes No
If yes, how long have you worn them? _____
If yes, do they provide relief? _____

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

18. Have you ever had your veins evaluated before? Yes No
If yes, when and where? _____

19. Have you ever had any test(s) done on your veins? Yes No

20. Have you ever had vein-stripping surgery? Yes No
If yes, which leg and when? _____

21. Have you ever had vein injections? Yes No
If yes, when, where and which leg? _____

Patient's Signature _____

Date _____

Provider's Signature _____

Date _____