

DATE _____
NAME _____
AGE _____ SEX _____
HEIGHT _____ WEIGHT _____
REFERRED BY: _____

1. Are you allergic to : medicines _____
local anesthetics _____
 2. How many years have you noticed this problem? _____
 3. Have you ever been previously treated for this problem? _____
With whom and when? _____
With what method? Injection _____
Electrocautery _____ Laser _____
Surgery _____
 4. When did your veins occur? Age _____
Before pregnancy _____ After pregnancy _____
After trauma _____ After birth control _____
or Premarin therapy _____ Other _____
 5. Is there a family history of varicose or spider veins? _____
Mother _____ Father _____
Sister _____ Brother _____
Children _____ Aunts _____
Uncles _____
 6. Do you have a history of? Please circle and indicate date occurred.)
Thrombophlebitis _____ Pulmonary embolus _____
Deep vein thrombosis _____ Sclera infection _____
Lupus _____ Hepatitis _____
Bleeding disorders _____ Easy bruising _____
Heart disease _____ Swollen feet/ankles _____
Migraine headaches _____ Asthma _____
HIV infection _____ Other _____
 7. Are you developing new veins? _____
 8. Are your present veins getting bigger? _____
 9. Have you ever had a venous ulcer? _____
 10. After prolonged standing or sitting do your legs ache? _____
 11. Do your legs or veins ache before menses? _____
 12. Does walking or exercise relieve or aggravate the pain? _____
 13. Are you required to be on your feet for long periods? _____
 14. Do you jog, run, jump rope, or do aerobics? _____
How often per week? _____
 15. Are you pregnant or planning a pregnancy soon? _____
 16. What medicines do you take? _____
Birth control pills, Premarin, or hormones? _____
Other _____
Aspirin or other over-the-counter medicines? _____
 17. Do you smoke cigarettes? _____
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