

# Varicose Vein Clinical Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Directions: Please answer the following questions. Provide your best estimate for dates 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, when, 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Heaviness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Tiredness/fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Itching/burning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Swollen ankles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Leg cramps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Restless legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs
Throbbing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One Leg	<input type="checkbox"/> Both Legs

Other? \_\_\_\_\_

2. Have your veins gotten worse in recent months?  Yes  No
3. Do you take any medication for pain (ie. advil, motrin)  Yes  No  
If yes, what medication do you take and how often? \_\_\_\_\_  
\_\_\_\_\_
4. Do you elevate your legs to relieve discomfort?  Yes  No  
If yes, does it provide relief?  Yes  No
5. Do you exercise, how often?  Yes  No
6. Do you wear prescription compression stockings?  Yes  No  
If yes, what type and how long have you worn them? \_\_\_\_\_  
If yes, what is the name of the physician who prescribed your compression stockings? \_\_\_\_\_  
\_\_\_\_\_

7. Do you wear light support hose (ie. sheer energy)?  Yes  No  
 If yes, do they provide relief?  Yes  No
8. Do you have any problem walking?  Yes  No  
 If yes, how does it affect you? \_\_\_\_\_
9. Do you stand much at work?  Yes  No  
 Do you stand much at home?  Yes  No
10. Have you ever had any test(s) done on your veins?  Yes  No  
 If yes, when, what type of test, and where on your legs? \_\_\_\_\_
- 
11. Were you diagnosed with saphenous vein reflux?  Yes  No

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENTS:** Please stop here. The physician may go over additional questions with you:

**Date of Initial Physical Evaluation:** \_\_\_\_\_

**Check all that apply:**

- Graduated, elasticized compression stockings, prescribed by a physician not in our practice, have been used by the patient for at least 3 months.
- Prescription for graduated, elasticized compression stockings given to patient.  
 Today  Given at an earlier date (specify date): \_\_\_\_\_  
 Proper instruction given for use of compression stockings.
- Instruction given for mild exercise. \_\_\_\_\_
- Instruction given for periodic leg elevation. \_\_\_\_\_
- Instruction given for weight reduction. \_\_\_\_\_  
 Weight reduction instruction is not appropriate for this patient.

**Initial Evaluation Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ M.D.  \_\_\_\_\_ M.D.

**Date of Physician Reevaluation:** \_\_\_\_\_

*(To review results of trial of conservative therapy-lasting at least 3-6 months):*

**Check all that apply:**

**Patient is symptomatic with varicosities despite compliance with conservative therapy.**

- Completed 3-6 month trial of compression stockings, leg elevation, mild exercise, and weight reduction (as appropriate)

**Patient is symptomatic with varicosities causing the following:**

- Has persistent aching, cramping, burning, pain, itching, and/or swelling during activity or after prolonged standing
- Significant, recurrent superficial phlebitis
- Hemorrhage from a ruptured varix
- Non-healing skin ulceration of the leg

**Duplex studies of deep venous system demonstrate:**

- Absence of deep venous thrombosis
- Greater and/or lesser saphenous vein valvular incompetence/ reflux that correlates with the patients symptoms

**Reevaluation Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ M.D.  \_\_\_\_\_ M.D.