NORTHWEST
Vein & Aesthetic Center
4700 Point Fosdick Dr, Suite 307 Gig Harbor, WA 98335
253-857-8346 (VEIN) www.nwveins.com

☐ Photos
☐ Measurements

VENOUS HISTORY

PATIENT NAME: _____ **DATE:**_____

How did you hear about us?_____

PERSONAL HISTORY OF VARICOSE VEINS OR SPIDER VEINS:

How many years have you had trouble with your veins? _____

What do or did you do for a living? _____

DO YOU HAVE …. (Please check):

☐Aching or throbbing ☐Itching ☐Burning pain in leg ☐Other:_____
☐Night cramps ☐Tired/Heavy legs ☐Skin changes
☐Red/warm areas ☐Tenderness ☐Restless legs
☐Ulcers or ulceration ☐Ankle/leg swelling
☐Leg pain ☐Hard lumps

Are your symptoms:

Worse with prolonged standing? **YES NO**
Worse with prolonged sitting? **YES NO**
Worse with menstrual cycle? **YES NO**
Relieved with rest/elevation of leg(s)? **YES NO**

Does your discomfort/leg pain interfere with any of the following activities of daily living?

☐Cleaning ☐Working ☐Driving ☐Sitting
☐Household Chores ☐Sleeping ☐Gardening ☐Meal Preparation
☐Walking ☐Bathing ☐Taking care of kids ☐Other_____
☐Running/Exercise ☐Standing

Please check if you have experienced any of the following:

☐Lower leg skin discoloration ☐Bleeding Disorder ☐HIV
☐Lower leg ulcers ☐Pulmonary Embolism ☐Hepatitis
☐Bleeding from veins ☐Deep Venous Thrombosis ☐MRSA
☐Superficial Phlebitis

Are you pregnant or nursing? **YES** **NO** **N/A**

FAMILY HISTORY OF VARICOSE VEINS OR SPIDER VEINS:

☐Mother ☐Father ☐Brother ☐Sister ☐Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐None

PREVIOUS CONSERVATIVE TREATMENT YOU HAVE TRIED:

Have you ever worn compression stockings for your veins? **YES NO**
When? _____ How Long? _____
How did they affect your symptoms (leg pain/swelling)?
Completely helped _____ Partially helped _____ Didn't help_____

- Do you take pain medications (Advil, Tylenol) for your leg pain/veins? **YES NO**
- Are your symptoms related to pregnancy? **YES NO**
- Are your symptoms related to accident/trauma? **YES NO**
- Are you developing new veins? **YES NO**
- Do you need to stop to elevate your legs throughout the day? **YES NO**
- Do your symptoms require you to make accommodations at work? **YES NO**
- Do you feel the need to sit after standing for a short period of time? **YES NO**

PREVIOUS TREATMENT HISTORY:

Ligation/Stripping surgery **YES** **NO** If so, which leg? _____ When? _____
Injection treatments **YES** **NO** If so, which leg? _____ When? _____
Laser therapy **YES** **NO** If so, which leg? _____ When? _____
Other: _____

Patient initials:_____ Provider initials: _____ Date: _____