VENOUS HEALTH HISTORY FORM

DATE: _____

NAME: _____ **DOB:** _____ **AGE:** _____

SEX: (M) (F) **PHONE:** _____ **EMAIL:** _____

MAY WE CONTACT YOU FOR FUTURE EVENTS? (Y) (N)

PLEASE ANSWER THE FOLLOWING QUESTIONS

A)	**Aching/pain in your legs?**	(Y) (N)	**Date of symptoms?** _____
B)	**Heaviness?**	(Y) (N)	**Date of symptoms?** _____
C)	**Tiredness/Fatigue?**	(Y) (N)	**Date of symptoms?** _____
D)	**Itching/Burning?**	(Y) (N)	**Date of symptoms?** _____
E)	**Swollen Ankles?**	(Y) (N)	**Date of symptoms?** _____
F)	**Leg Cramps?**	(Y) (N)	**Date of symptoms?** _____
G)	**Restless Legs**	(Y) (N)	**Date of symptoms?** _____
H)	**Throbbing?**	(Y) (N)	**Date of symptoms?** _____
I)	**Other?**	(Y) (N)	**Date of symptoms?** _____

If yes, please describe: _____

_____

_____

J) Do you experience these problems in just one or both legs? RIGHT LEFT BOTH

SECTION BELOW FOR DOCTOR USE ONLY

EXAM

RIGHT LEG	LEFT LEG
◯ Spider Vein	◯ Spider Vein
◯ Varicose Vein	◯ Varicose Vein

ULTRASOUND

RIGHT LEG	LEFT LEG
◯ Reflux	◯ Reflux

SCHEDULE ◯ Consultation ◯ Ultrasound ◯ Laser