GREENSBORO IMAGING

PATIENT VENOUS HISTORY

Patient Name: _____ Date of Birth _____

1. Have you had any prior treatment for varicose/spider veins? YES NO
   Date(s) of treatment_____
   Type of agent(s) used, if known_____
2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis? YES NO
3. Do you have a family history of varicose/spider veins? YES NO
   If so, relationship(s) to you _____
4. Are you currently, or have you been on any hormone therapy of birth control pills? YES NO
   If so, please list_____
5. Have you had any pregnancies? If so, how many? _____ YES NO
   If so, did your varicose/spider veins increase after your pregnancies? YES NO
6. Do you wear support hose? If yes, are they prescription or over-the-counter? YES NO
7. Are you presently employed? If so, type of job _____ YES NO
8. Do you sit or stand for long periods of time? How many hours per day? _____ YES NO
9. Do you take any pain medications for your varicose/spider veins (Aspirin/Tylenol)? YES NO
10. Do you elevate your legs to relieve your symptoms? If so, does it work? YES NO

Additional History _____

_____

COMPREHENSIVE HISTORY CHECKLIST
(Please check all those that apply)

	Right Leg	Left Leg
Edema		
Pain		
Tiredness		
Ulceration		
Skin Color Changes		
Spider Veins		
Varicose Veins		

Patient Signature: _____ Date: _____