



Wisconsin Vein Center & MediSpa

Confidential Health History

Name: _____ Age: _____ Date: _____

Occupation: _____ Hours standing per day: _____

Which leg bothers you? Right Left Both

SYMPTOMS please check if you have:

- Ache or hurt
- Swell
- Cramp
- Become restless
- Become tired/heavy
- Itch/burn
- Ulceration/skin changes on leg
- Bleeding from a bulging vein
- Leg discomfort with menses
- No symptoms

For Women:

- Pelvic heaviness
- Symptoms worsen with menses

What **treatments** have you tried to relieve these symptoms?

- Analgesic Usage Compression Hose Elevation Walking

Number of year's symptoms has been present _____

Have you ever had any previous vein treatments? Yes No

If yes, what treatments have you had?

- Vein stripping
- Laser ablation
- Radiofrequency ablation
- Sclerotherapy
- Other

Have you ever worn compression hose? Yes No

If yes, # of years worn: _____

Please list any **surgeries** you have had _____

Do you have any **allergies**? Yes No

If Yes, please list: _____

Reaction: _____

Please list any **medications** you take _____

Do you smoke? Yes No If Yes, how many per day? _____

Do you drink alcohol? Yes No

If yes, please check what type Beer Wine Other _____

How often do you drink? _____

Do you use any illicit drugs? (Cocaine, Marijuana) Yes No

How often do you exercise? Daily Weekly Frequently Not Regularly

Are you currently being treated for or have any history of:

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Ankle Skin changes | <input type="checkbox"/> Leg ulcers or non-healing wounds |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Chest pain discomfort | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Clotting / bleeding disorders | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Pulmonary embolus |
| <input type="checkbox"/> Crohn's disease, IBS | <input type="checkbox"/> Rupture of vein |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Deep vein thrombosis/blood clot in leg | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Structural heart defect |
| <input type="checkbox"/> Easy bruisability | <input type="checkbox"/> Superficial Thrombophlebitis
(red or hard vein) |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Trauma to legs / leg fracture |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Men: Testicular Varicosities |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Women: Vulvar (Labial) varicosities |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Is there a family history of varicose vein disease? Yes No

Are you pregnant? Yes No

of pregnancies _____ # of live births _____

