



Carolina Vascular
surgery & diagnostics

Patient Medical Venous History

Chart # _____

Picture # _____

Name _____

Date of Birth _____

Last	First	MI
Have you had any prior treatment for varicose/spider veins?		
Date(s) of treatment _____		
Type of agent(s) used, if known _____		

YES NO

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 or 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? RX OC
7. Are you presently employed? If so, type of job _____ YES NO
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 (Motrin, Alleve)? YES NO
10. Do you elevate your legs to relieve your symptoms? YES NO
If so, does it work? YES NO
11. Have you received and read the Sclerotherapy brochure? YES NO

Additional History _____

COMPREHENSIVE HISTORY CHECKLIST (Please check all those that apply)

	Right Leg	Left Leg
Swelling		
Pain		
Skin Color Changes		
Spider Veins		
Varicose Veins		