

Name: _____
 Chart: _____ Date: _____
 DOB: _____ Age: _____

Sentara Surgery Specialists
 Sentara Medical Group

PRIMARY PHYSICIAN

SEX: Male Female

Date: _____

Directions: Please answer the following questions. Provide your best estimate for dates of occurrence.

Past Medical History

- | | | |
|---------------------------------------|-----|----|
| 1. Have you ever had vein stripping? | Yes | No |
| If yes, when and which leg? _____ | | |
| 2. Have you ever had vein injections? | Yes | No |
| If yes, which leg and where? _____ | | |
| 3. Have you ever had a blood clot? | Yes | No |
| If yes, when and which leg? _____ | | |
| 4. Have you ever had phlebitis? | Yes | No |
| If yes, when and which leg? _____ | | |

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs?

- | | | |
|------------------|-----|----|
| Father | Yes | No |
| Mother | Yes | No |
| Brother(s) | Yes | No |
| Sister(s) | Yes | No |
| Other | Yes | No |

1. Do you experience any of the following?

- | | | |
|--|-----|------|
| a. Aching/pain in your legs?..... | Yes | No |
| b. Heaviness?..... | Yes | No |
| c. Tiredness/fatigue? | Yes | No |
| d. Itching/burning? | Yes | No |
| e. Swollen ankles? | Yes | No |
| f. Leg cramps? | Yes | No |
| g. Restless legs? | Yes | No |
| h. Throbbing? | Yes | No |
| Other?..... | Yes | No |
| Do you experience these problems in just one, or both legs?..... | One | Both |

2. Have your veins gotten worse in recent months?..... Yes No

3. Do you take any medication for pain (eg. Advil, etc.)..... Yes No

If yes, what medication and how often?_____

4. Do you elevate your legs to relieve discomfort? Yes No

5. Do you wear support hose prescribed by a doctor? Yes No

If yes, what type and how long have you worn them?_____

6. Do you wear light support hose (eg. Sheer Energy, etc.)?..... Yes No

7. Do they provide relief? Yes No

8. Do you have any problem walking? Yes No

If yes, how does it affect you?_____

9. Do you stand much at work? Yes No

Do you stand much at home? Yes No

10. Have you ever had any test(s) done on your veins? Yes No

If yes, when, what type of test and where on the leg?_____

11. Were you diagnosed with saphenous vein reflux? Yes No

12. Please list all Medications including Birth Control. _____

