Jana Emmett, MMSc. PA-C

Venous Patient Health History Form

Name: _____ Date: _____

Age: _____ DOB:_____ Sex: M / F Height: _____ Weight: _____

Directions: Please answer the following questions, trying not to leave any blank spaces

What is your biggest concern with your legs?

_____

_____

Allergies

Do you have any allergies? (specifically to medications, cleansers, or tape) Yes No
If yes, what are you allergic to? (please list allergy and reaction).

_____

_____

Past Medical History

1. Have you ever had vein stripping surgery? Yes No
   If yes, when, and which leg? _____
2. Have you ever had saphenous vein ablation? (radiofrequency or laser) Yes No
   If yes, which leg and when? _____
3. Have you ever had vein injections? Yes No
   If yes, when, and in which leg? _____
4. Have you ever had a blood clot in a deep leg vein? Yes No
   If yes, which leg and when? _____
5. Have you ever had a superficial phlebitis? Yes No
   If yes, which leg and when? _____
6. Do you experience any of the following?

Aching/pain?	Yes	No	LT/RT leg	Both legs
Heaviness?	Yes	No	LT/RT leg	Both legs
Tiredness/fatigue?	Yes	No	LT/RT leg	Both legs

Itching/burning?	Yes	No	LT/RT leg	Both legs
Swollen ankles?	Yes	No	LT/RT leg	Both legs
Leg cramps?	Yes	No	LT/RT leg	Both legs
Restless legs?	Yes	No	LT/RT leg	Both legs
Throbbing in legs?	Yes	No	LT/RT leg	Both legs

7. Does anyone in your family have spider veins or varicose veins? Yes No

   If yes, who, and what kind of veins? _____

8. Do you exercise? Yes No

   If yes, what kind of exercise, and how often? _____

9. Do you wear support (over the counter) or prescription stockings? Yes No

   If yes, which? _____ Do they provide relief? _____

10. What type of work do you do? _____

    Does it require long periods of standing? _____

11. Have you ever had a duplex ultrasound study of your legs? Yes No

    If yes, when and where was it done? _____

12. Have you ever had a pulmonary embolus? _____

13. Do you have heart disease? Yes No

Lung disease?	Yes	No
High blood pressure?	Yes	No
Hepatitis?	Yes	No
Arthritis?	Yes	No
HIV/AIDS?	Yes	No
Blood clotting disorder?	Yes	No
Easy bruising?	Yes	No
Diabetic?	Yes	No

Medications

Please list any medications you are currently taking (including vitamins, birth control pills or other hormones).

_____

_____

_____

Past Surgical History

Please list all past surgeries:

_____

_____

_____

Pregnancy and Breastfeeding

1. Are you pregnant, think you may be, or actively trying to become pregnant?
   Yes No
2. Are you breastfeeding? Yes No

Please keep in mind that you should not have sclerotherapy if you are pregnant, think you may be pregnant or are actively trying to become pregnant, or are breastfeeding.

Thank you for completing this history.

Signature: _____

Date: _____