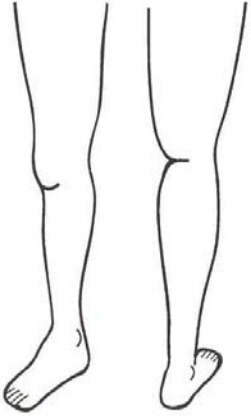
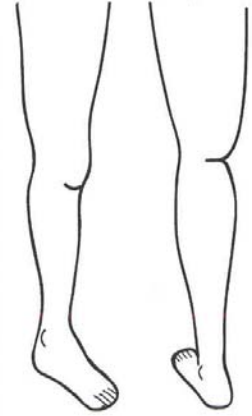


## VENOUS HEALTH HISTORY FORM

Please complete front side (only) of this form.

<b>Name:</b>			<b>DOB:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Date:</b>
<b>PCP Name:</b>			<b>How did you hear about us?</b> <input type="checkbox"/> Physician Referral: _____		
<b>Provider:</b> <input type="checkbox"/> Buzzas <input type="checkbox"/> Van Amburg			<input type="checkbox"/> Phone Book <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____		
<b>I. Vascular History</b>			<b>II. Family History</b>		
<b>Do you have or have you ever been diagnosed with:</b>			<b>Have any of your family members had:</b>		
Varicose vein problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> N	Who? _____
Phlebitis (vein redness/tenderness)	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Vein stripping	<input type="checkbox"/> Y <input type="checkbox"/> N	Who? _____
Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Blood coagulation disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	Who? _____
Deep vein thrombosis (DVT)	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> N	Who? _____
Saphenous vein reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Stroke, heart attacks or pulmonary emboli	<input type="checkbox"/> Y <input type="checkbox"/> N	Who? _____
<b>Do you experience any of the following in your leg(s):</b>			<b>III. Vein Treatment History</b>		
Aching/Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	<b>Have you ever been treated for varicose veins with:</b>		
Heaviness	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Sclerotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Tiredness/Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Laser therapy (spider veins)	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Itching/Burning	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Phlebectomy	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Vein stripping surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Cramps	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	RF ablation (VNUS Closure®)	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Restless legs	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	RF Laser Ablation (EVLT)	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L
Throbbing	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L			
Skin or Ulcer problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L			
Other	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg: <input type="checkbox"/> R <input type="checkbox"/> L			
			<b>IV. Personal/Activities List</b>		
			Do you exercise?	<input type="checkbox"/> Y	How often? _____ <input type="checkbox"/> N
			Do you smoke?	<input type="checkbox"/> Y	# Per day? _____ <input type="checkbox"/> N
			Pregnancies	<input type="checkbox"/> Y	How many? _____ <input type="checkbox"/> N
<b>Do you do any of the following to improve your leg vein symptoms:</b>			Prolonged sitting/standing periods	<input type="checkbox"/> Y <input type="checkbox"/> N	
Medication for pain	<input type="checkbox"/> Y <input type="checkbox"/> N	What? _____	<b>Does your work require:</b>		
Elevation of legs	<input type="checkbox"/> Y <input type="checkbox"/> N	When? _____	Prolonged standing periods	<input type="checkbox"/> Y	How long? _____ <input type="checkbox"/> N
Wear compression hose	<input type="checkbox"/> Y <input type="checkbox"/> N	When? _____	Prolonged sitting periods	<input type="checkbox"/> Y	How long? _____ <input type="checkbox"/> N
How long did you wear them?			Heavy lifting?	<input type="checkbox"/> Y	# lbs? _____ <input type="checkbox"/> N
			<b>V. Activity restrictions due to leg symptoms:</b>		

V. Location of veins (to be completed by provider)	
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>RIGHT LEG</p>  <p>Anterior    Posterior</p> </div> <div style="text-align: center;"> <p>LEFT LEG</p>  <p>Anterior    Posterior</p> </div> </div>	<p><b>RIGHT LEG</b> (check all that apply)</p> <p><input type="checkbox"/> No signs of venous disease      <input type="checkbox"/> Spider veins</p> <p><input type="checkbox"/> Visible varicose veins              <input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Pigmentation    <input type="checkbox"/> Healed ulcers    <input type="checkbox"/> Active ulcers</p>
	<p><b>LEFT LEG</b> (check all that apply)</p> <p><input type="checkbox"/> No signs of venous disease      <input type="checkbox"/> Spider veins</p> <p><input type="checkbox"/> Visible varicose veins              <input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Pigmentation    <input type="checkbox"/> Healed ulcers    <input type="checkbox"/> Active ulcers</p>
	<p><b>Clinical Assessment:</b></p> <p><input type="checkbox"/> Chronic venous insufficiency      <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> Other                                      <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p>
	<p><b>Physical Exam:</b></p>
	<p><b>Treatment Plan:</b></p> <p><input type="checkbox"/> Duplex ultrasound                      <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> RFA                                              <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> Phlebectomy                              <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> Sclerotherapy                              <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> Medical Comp Stockings              <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p> <p><input type="checkbox"/> Other:                                              <input type="checkbox"/>R   <input type="checkbox"/>L   <input type="checkbox"/>BILAT</p>
<p><b>CEAP Clinical Signs:</b></p>	
<p><b>Notes:</b></p>	

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_