



1510 South Central Avenue Suite 200 • Glendale, CA 91204
1 888 SO CA VEINS (1.888.762.2834) (818) 500.9934 FAX (818) 500.9935
www.varicoseveinsurgeons.com email: contact@varicoseveins.com

Venous Medical History

Patient Name: _____

Date: _____

Marital Status: _____

Occupation: _____

Impact on your symptoms: _____

Primary care physician: _____

Date of birth: _____

Please list any allergies you have:

Are you seeking treatment for your veins?

Medical reasons: _____

Cosmetic reasons: _____

How long have you had veins you are concerned about? _____

Did your veins develop during a pregnancy? _____

How many pregnancies? _____

Does prolonged sitting or standing aggravate your veins? _____

Last menstrual period? _____

Are your veins getting worse? _____



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Have you ever had treatment for your veins, if yes and what type of treatment?

How does it affect daily living?

Do your legs ever experience (please circle if appropriate)

Pain	Swelling	Aching	Redness	Inflammation
Heaviness	Tiredness	Fatigue	Burning	Restless legs
Edema	Throbbing	Leg cramps	Itching	Paraesthesias

Have you ever been treated for a blood clot in your legs, if yes when and which leg?

Any family history of bleeding, blood disorders, or blot clots?

Have you ever worn compression hose, if yes for how long and did it help your veins?



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Do you use medications or analgesics to improve your symptoms?

Have you ever had ulcers or bleeding from varicose veins?

Please list any medications you are currently taking:

Please circle any of the following medical problems that you have:

High blood pressure	Cancer	Heart disease	Lung disease
Asthma	Diabetes	Liver disease	

Family history of varicose veins:

Please list any pertinent medical conditions you have that we have not listed



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Please list previous surgeries and dates:

Picture taken:

Hose prescribed:

Social history:

Smoker: Yes Packs a day
 No

Alcohol intake: _____



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Remainder to be filled out by Staff

Upon Examination Patient has:



Picture Taken: _____

Hose Prescribed: _____

Social History Smoker Yes_____ Pk/day_____ No_____

Alcohol Intake _____