COLUMBUS VASCULAR CENTER

PATIENT HISTORY FORM

Name: **Birth Date:** **Age:** **Date:**

Chief Complaint:

Occupation: **Number of Children: __**

Do you experience any of the following?	**YES**	**NO**
Aching/pain/cramps in your legs	☐	☐
Tiredness/fatigue	☐	☐
Itching/burning	☐	☐
Swollen ankles	☐	☐
Throbbing	☐	☐
Have your veins gotten worse in recent months?	☐	☐
Do you elevate your legs to relieve discomfort?	☐	☐
Have you been prescribed support hose?	☐	☐
If yes, are you able to wear your prescribed hose?	☐	☐
Do you have any problems walking or use a cane?	☐	☐
Do you stand much at work or at home?	☐	☐
Do you have/ ever had any of the following?	**YES**	**NO**
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Blood clot in legs	☐	☐
Vein stripping surgery	☐	☐
Vein injections	☐	☐
Phlebitis	☐	☐

Prior Surgeries/Year:

Allergies:

Medications: (Bring a list or provide written copy)

Social History:	YES	NO	FREQUENCY
Do you drink alcoholic beverages?	☐	☐	
Do you currently smoke?	☐	☐	
Have you ever smoked? If so, how many years?	☐	☐	
Do you have elevated cholesterol?	☐	☐	
Are you generally stressed?	☐	☐	
Do you drink beverages containing caffeine?	☐	☐	
Do you exercise?	☐	☐	

If yes what is your routine: __

Do you have any relevant family history (i.e. family history of vein problems)?