HEALING
Internal Medicine Clinic

Venous Health History & Treatment Plan Options

Patient Name:_____ Date of Birth: _____

Height:_____ Weight: _____

1. Has the patient ever had phlebitis? ☐Yes ☐No
2. Has the patient ever had vein injections? ☐Yes ☐No
3. Has the patient ever had blood clots? ☐Yes ☐No

History

Does anyone in the patient's family have (or used to have) varicose veins, spider veins, leg ulcers, swollen legs or vein stripping?

Father	☐Yes	Brother	☐Yes
Mother	☐Yes	Sister(s)	☐Yes
Other:	☐Yes		

1. The patient experiences the following:

Aching/pain?	☐Yes	☐LT / RT leg	☐Both
Heaviness?	☐Yes	☐LT / RT leg	☐Both
Tiredness/fatigue?	☐Yes	☐LT / RT leg	☐Both
Itching/burning?	☐Yes	☐LT / RT leg	☐Both
Swelling?	☐Ye	☐LT / RT leg	☐Both
Leg cramps?	☐Ye	☐LT / RT leg	☐Both
Restless legs?	☐Ye	☐LT / RT leg	☐Both
Throbbing?	☐Ye	☐LT / RT leg	☐Both

2. Have the patient's veins gotten worse in recent months? ☐Yes ☐No
   Describe**:**
3. Does the patient take any medication for pain (i.e., Advil, Motrin) ☐Yes ☐No
   If yes, what medication(s)?
4. Does the patient elevate their legs for relief? ☐Yes ☐No
5. Does the patient exercise? ☐Yes ☐No
6. Do you wear compression stockings? ☐Yes ☐No
7. Does the symptoms interfere with ADL's? ☐Yes ☐No
   If yes, describe how it interferes with your activities of daily living, which activities:
   _____
8. Have you ever had any test(s) done on your veins? ☐Yes ☐No