ADVANCED CARDIO VASCULAR CARE
A Cardiac & Vein Center of Excellence

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Venous Health History Form

Name:_____ Date:_____

Age: ____ years Sex: M F

1. Have you ever had vein stripping surgery? Yes No
2. Do you experience any of the following in your legs?
   a. Aching/pain? ---------- Yes No
   b. Heaviness? ---------- Yes No
   c. Tiredness/fatigue? ---------- Yes No
   d. Itching/burning? ---------- Yes No
   e. Swollen ankles? ---------- Yes No
   f. Leg cramps? ---------- Yes No
   g. Restless legs? ---------- Yes No
   h. Throbbing? ---------- Yes No
   i. Varicose Veins? ---------- Yes No
   Other? ---------- Yes No
   Do you experience these problems in just one or both legs? One Both
3. Do you take any medication for pain (i.e., Advil, etc.) Yes No
   If yes, what medication and how often? _____
4. Do you elevate your legs to relieve discomfort? Yes No
5. Do you wear support hose prescribed by a doctor? Yes No
   If yes, how long have you worn them? _____
6. Do you have any problem walking? Yes No
   If yes, how does it affect you? _____
7. Do you stand much at work? Yes No
   At home? Yes No
8. Have you ever had any test (s) done on your veins? Yes No
   If yes, when, what type of test and where on the leg? _____
   _____
9. Have you been diagnosed with saphenous vein reflux? Yes No