



# SANTA BARBARA - VEIN CENTER -

## VEIN HEALTH & HISTORY FORM

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Last First M.I.

DOB: \_\_\_\_\_ Are you requesting evaluation at SBVC for medical reasons? Yes No

What is your chief medical concern? \_\_\_\_\_

What about your legs would you most like to correct? \_\_\_\_\_

### VASCULAR HISTORY

Indicate whether you have ever experienced any of the following: (check all that apply)

- \_\_\_\_\_ burning/itching/tingling      \_\_\_\_\_ heaviness/fatigue      \_\_\_\_\_ pain/discomfort/cramping
- \_\_\_\_\_ generalized leg swelling      \_\_\_\_\_ ankle swelling      \_\_\_\_\_ restless legs
- \_\_\_\_\_ worsening leg veins      \_\_\_\_\_ bulging leg veins      \_\_\_\_\_ phlebitis (vein inflammation)
- \_\_\_\_\_ leg ulcers or sores      \_\_\_\_\_ red spider veins      \_\_\_\_\_ skin discoloration below knee

Do you have a family history of vein disease? Yes No

Have you ever smoked tobacco? Yes No

Have you ever had a substance abuse problem? Yes No

Are you required to sit or stand for prolonged periods? Yes No For how long? \_\_\_\_\_

When did your vein problem first start? \_\_\_\_\_

Have you worn compression stockings before? Yes No For how long? \_\_\_\_\_

When did you start wearing support stockings? \_\_\_\_\_

Some insurance plans require that compression hose be worn 6 months prior to request for treatment

What relieves your vein symptoms? \_\_\_\_\_

What makes your vein symptoms worse? \_\_\_\_\_

When did you start using pain medications for leg problems (aspirin, Tylebol, ibuprofen)

\_\_\_\_\_

Have you been previously evaluated for a vein problem? Yes No Explain: \_\_\_\_\_

Indicate which prior vein treatments you have had: (check all that apply)

\_\_\_\_\_ sclerotherapy injections    \_\_\_\_\_ surgical ligation    \_\_\_\_\_ surgical vein stripping  
\_\_\_\_\_ ambulatory phlebectomy    \_\_\_\_\_ radiofrequency closure    \_\_\_\_\_ endovenous laser ablation

## **MEDICAL HISTORY**

List your current medications: \_\_\_\_\_

Do you have any medication allergies? Yes No Explain: \_\_\_\_\_

Do you have a latex allergy? Yes No Explain: \_\_\_\_\_

Do you have sensitivities to tape? Yes No Explain: \_\_\_\_\_

List prior surgery \_\_\_\_\_

List medical conditions you are being treated for: \_\_\_\_\_

Indicate which of the following medical conditions you have had: (check all that apply)

\_\_\_\_\_ blood clotting disorder    \_\_\_\_\_ anemia or bleeding    \_\_\_\_\_ PFO or heart defect  
\_\_\_\_\_ migraine headaches    \_\_\_\_\_ high blood pressure    \_\_\_\_\_ diabetes  
\_\_\_\_\_ asthma or lung disease    \_\_\_\_\_ pulmonary embolism    \_\_\_\_\_ deep vein thrombosis  
\_\_\_\_\_ Phlebitis or vein inflammation    \_\_\_\_\_ vein rupture (bleeding)    \_\_\_\_\_ stroke or CVA  
\_\_\_\_\_ Coronary artery disease    \_\_\_\_\_ peripheral artery disease    \_\_\_\_\_ kidney disease  
\_\_\_\_\_ Hepatitis or liver disease    \_\_\_\_\_ joint replacement surgery    \_\_\_\_\_ cancer or malignancy  
\_\_\_\_\_ HIV/AIDS    \_\_\_\_\_ leg trauma    \_\_\_\_\_ other

## **For Women Only**

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Ages of children \_\_\_\_\_

Number of miscarriages \_\_\_\_\_ Are you pregnant or planning to get pregnant? Yes No

Do you have more leg discomfort around the time of your menstrual period? Yes No

\_\_\_\_\_

**FAMILY HISTORY**

Is there a history in your family of varicose veins?    Mother    Father    Siblings    Child

Is there a history in your family of deep vein thrombosis, or clotting disorders?

Mother                      Father                      Siblings                      Child

**REVIEW OF SYSTEMS**

Do you have any of the following symptoms? If yes, please circle and explain on the following line.

Constitutional: Fevers, chills, recent unexplained loss of appetite or weight?

\_\_\_\_\_  
Head: Frequent headache or migraine?

\_\_\_\_\_  
Eyes: Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting?

\_\_\_\_\_  
ENT: Recent change in hearing, nasal discharge, sore throat, dizziness or ringing in the ears?

\_\_\_\_\_  
Cardiac: Chest pain, shortness of breath, waking from sleep breathless?

\_\_\_\_\_  
Gastrointestinal: Change in bowel habits, black or bloody stools, vomiting or belly pain?

\_\_\_\_\_  
Musculoskeletal: Change in walking ability or strength. Painful joints?

\_\_\_\_\_  
Skin: Rashes or itching, changes in skin color or sores that won't heal?

\_\_\_\_\_  
Neurological: Unexpected, unexplained numbness, tingling or weakness in an arm or leg?

\_\_\_\_\_  
Patient or Responsible Party Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_      Date Signed: \_\_\_\_\_

\_\_\_\_\_  
RN signature                      Date                      Physician Signature                      Date