Vein Care of Brevard

Name: _____ Age_____

1. At what age did you notice your veins _____
2. Are your veins getting worse? yes no
3. Do you bruise fairly easily? yes no
4. Are you developing new veins? yes no
5. Are your veins getting bigger? yes no
6. Are your veins bothered by:
   - Aching? yes no
   - Throbbing? yes no
   - Numbness or Tingling? yes no
   - Burning? yes no
   - Itching? yes no
   - Fullness or Pressure? yes no
   - Swelling? yes no
   - Tiredness or Heaviness? yes no
   - Muscle Cramping? yes no
   - Skin or Ulcer Problems? yes no
   - Leg Restlessness? yes no
7. Do your legs feel worse:
   - After prolonged sitting or standing? yes no
   - During menstrual period? yes no
   - During warm weather? yes no
   - While walking? yes no
8. Do your legs feel better: yes no
   - After elevating them? yes no
   - While walking? yes no
   - While wearing support stockings? yes no
9. Does your work require:
   - Prolonged periods of standing? yes no
   - Prolonged periods of sitting? yes no
10. Are you pregnant? yes no
11. Are you planning a pregancy soon? yes no
12. Have you ever been pregnant? yes no
13. How many pregnancies? yes no
14. Did Varicose veins begin with pregnancies? yes no
15. Ages of children _____
16. Circle if you've had the following treatment for your veins: Surgery Injections Laser Other
    Date(s): _____ Results: _____
17. Have you ever worn support stockings? Yes No For how long?
18. Have you ever taken aspirin, Tylenol or Advil (even once) for leg pain? Yes No
19. Do you have a family history of varicose veins? Yes No
20. Have you ever been treated for:
    - phlebitis (inflammation of vein)? Yes No
    - deep vein thrombosis (blood clot in the legs) Yes No
    - pulmonary embolism (blood clot in the lungs)? Yes No
21. List known medical _____
_____

MEDICATIONS: LIST ALL THAT YOU ARE CURRENTLY TAKING (Including aspirin, insulin, vitamins, etc)

Medication Name	Dose	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____YES _____NO

I am allergic to:	The reaction I have if I take this medication:
_____	_____
_____	_____
_____	_____
_____	_____

I assume sole responibility that the above medications listed above are correct.
Patient Name: _____ Date: _____
Witness Signature: _____