Rocky Mountain
SURGICAL SOLUTIONS
2831 Fort Missoula Road, Building #2, Suite 104, Missoula, Montana 59804
Ph 406 728 0285, Fax 406 728 0613 www.rockymountainsurgicalsolutions.com

Patient Venous History

Patient Name :_____ DOB:_____

Have you had any previous treatment for varicose/spider veins? (i.e.: vein stripping, sclerosing) Yes No
Date(s) of treatment:_____

Have you ever had any vein injections? Yes No
If yes, which leg and where?:_____

Do you have any history of ulcerations, clots in the veins, deep vein thrombosis, or phlebitis? Yes No

Do you have a family history of varicose/spider veins? Yes No
If yes, what is the relationship to you?:_____

Are you currently or have you been on any hormone therapy or birth control pills? Yes No
If yes, please list the type:_____

Have you had any pregnancies? If so, how many?_____ Yes No
If yes, did your varicose/spider veins increase? Yes No

Have you worn compression stockings? Yes No
If yes, are they prescription or over the counter?:_____
How long have you worn them?:_____

Are you currently employed? Yes No
If yes, what type of job?:_____

Do your varicose veins interfere with your job? Yes No

Do you sit or stand for long periods of time? Yes No
How many hours per day?:_____

Do you take any pain medications for your varicose/spider veins? Yes No
If yes, what type?:_____ How often?:_____

Do you elevate your legs to relieve any of your symptoms? Yes No
If yes, does it help? Yes No

Do you have severe or persistent pain that interferes with daily activities? Yes No

Do you exercise? Yes No
If yes, how often?:_____ What type?:_____

Patient Signature:_____ **Date:**_____

Comprehensive History Check List
(Please check all that apply)

	Left	Right	Both		Left	Right	Both
Edema (Fluid accumulation)	☐	☐	☐	Aching	☐	☐	☐
Pain / Throbbing	☐	☐	☐	Heaviness	☐	☐	☐
Tiredness / Restless Legs	☐	☐	☐	Itching / Burning	☐	☐	☐
Ulceration	☐	☐	☐	Swollen ankles	☐	☐	☐
Skin changes (color)	☐	☐	☐	Leg cramps	☐	☐	☐