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Varicose Vein and Spider Vein Procedure
Patient Health History Form

Patient Name: _____
Referred By: _____

Date: _____

Years with Varicose/Spider Veins: _____

Vein/Skin Conditions: (Please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Purple Vein Networks | <input type="checkbox"/> Chest or Breast Veins |
| <input type="checkbox"/> Small Red "Spider" Veins | <input type="checkbox"/> Flat Blue-green Veins | <input type="checkbox"/> Facial Veins |
| <input type="checkbox"/> Diagnosed with Vein Disease | <input type="checkbox"/> Abdominal Veins | <input type="checkbox"/> Ankle Sores |
| <input type="checkbox"/> Purple Veins | <input type="checkbox"/> Bulging Veins | |
| <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Vaginal Veins | |

Other: (Describe) _____

Leg and Ankle Problems: (Please explain "Yes" answers)

- | | | |
|--------------|--|-------|
| Aches | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Swelling | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Heaviness | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Itching | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Restlessness | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other | | _____ |

| |
|---|
| <p>Do your daily activities require prolonged periods of standing? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what activity requires prolonged period of standing?</p> <p>If yes, how many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities? (Please answer this question regarding these symptoms as they were experienced PRIOR to any recent trial of compression stockings)</p> <p>Never <input type="checkbox"/> Once per day <input type="checkbox"/> 2-3 times per day <input type="checkbox"/> 4 or more times per day <input type="checkbox"/></p> <p>Do you take over the counter medications (e.g. aspirin, ibuprofen, NSAIDS or a similar type of medication) or prescription medication for aching, cramping, burning or swelling of lower extremities?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes what is the medication and dosage?</p> |
|---|

If yes, how many days in a two week period of time do you take the medication? (Please answer this question regarding these symptoms as they were experienced PRIOR to any recent trial of compression stockings)

0-2 Days 3-4 days 5-6 days 7 or more days

Methods used to relieve leg discomfort:

- | | |
|--|---|
| <input type="checkbox"/> No discomfort | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Leg elevation | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Flexion/Extension of feet | <input type="checkbox"/> Compression hose |
| <input type="checkbox"/> Walking | Brand: _____ How long? _____ |
| <input type="checkbox"/> Warm soaks | <input type="checkbox"/> Cold packs |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Wraps |
| <input type="checkbox"/> Ibuprofen | |

Other: _____

Family History

Spider/Varicose veins

- None
- Mother
- Father
- Son/Daughter
- Grandparents
- Sisters/Brothers
- Aunt/Uncle
- Other _____

Family History

Deep Thrombosis, Stroke, Clotting disorders

- None
- Mother
- Father
- Son/Daughter
- Grandparents
- Sisters/Brothers
- Aunt/Uncle
- Other _____

Conditions Patient Had/Has:

- | | | |
|------------------------------|------------------------------------|------------------------------|
| None | Diabetes | Lupus |
| Anemia | Easy Bruising | Migraine Headaches |
| Ankle Skin Changes | Heart Disease | Mitral valve Prolapsed |
| Atherosclerosis | Hepatitis | Pulmonary Embolus |
| Bleeding/Blood Disorder | High Cholesterol | Rupture of Vein |
| Chest Pain or Discomfort | HIV/AIDS | Stroke |
| Constipation | Hypertension (high blood pressure) | Superficial Thrombophlebitis |
| Crohn's Disease/IBS | Kidney Disease | Trauma to legs |
| Deep Vein Thrombosis/Clot | Leg Ulcers | Other _____ |
| Diabetes (Insulin Dependent) | Liver Disease | |

Current Medical Situation:

Any allergy to medications or other substance? Yes No

If yes, please list: _____

Any current illnesses?

Yes No

If yes, please list: _____

Current Medications, Vitamins, or Herbal Supplements:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are you now or are you planning to be pregnant?

Yes No

Are you currently breast feeding?

Yes No

Do you have discomfort around your menses?

Yes No

How many miscarriages have you had? _____

How many pregnancies have you had? _____

Social History:

Occupation: _____

On feet for long periods of time?

Yes No

If yes, in what capacity: _____

Walking: Increases Discomfort

Decreases Discomfort

Smoker: Yes No

Smoke per day: _____

Alcohol Use: Yes No

Drinks per day: _____

Past Surgeries: (Date and Type of Surgery)

Abdominal _____

Heart _____

Head and Neck _____

OB/GYN _____

Breast _____

Orthopedic _____

Other _____

Endovenous laser ablation Leg: Rt Lt Both Date _____ Provider _____

Ligation and/or stripping Leg: Rt Lt Both Date _____ Provider _____

Radio-frequency ablation Leg: Rt Lt Both Date _____ Provider _____

Spider vein injections Leg: Rt Lt Both Date _____ Provider _____

Spider vein laser therapy Leg: Rt Lt Both Date _____ Provider _____

Stab Phlebectomy Leg: Rt Lt Both Date _____ Provider _____

Varicose Vein Injections Leg: Rt Lt Both Date _____ Provider _____

What were the results of the above treatments? _____

Other:

What would you most like to correct about your legs? _____