Venous Health History Information

TEL 904-276-9222 • FAX 904-276-7559 www.nfvein.com

C O N F I D E N T I A L

Please fill this out prior to your visit. You may bring it in with you at the time of your appointment or you may, mail, or fax it to our office prior to your visit.

Date: ______________________________

Name____ Gender Male ____ Female ____

Address ____ Date of Birth ___ /___ /__________

City __________________________ ST____ Zip ___________ Tel: ___________________________

How did you hear about us? ___________________________ Email: _________________________
(If A Publication Please Specify)

Refereeing Physician: __________________________________

In order to better serve you please complete the following information with your best estimate of dates for treatment of occurrence or procedures if any you have had in the past.

1. Have you ever been treated for varcouse veins? Yes _______No______ If yes, when _____
2. If yes which leg? Left or right ______ or Both ________ For how long? ____________
3. Date of treatment: __________________________________ Physician ______________
4. Have you had Vein Injections? Yes _______or No _________ (If yes, when) ___________
5. If yes which leg? Right ___________or Left __________or both_____________________
6. Where on the e.g. was treatment performed? _____________________________________
7. Date of treatment____________________________________ Outcome _______________
8. Have you worn Compression Hose? Yes________No______
9. If yes, when and for how long ____
10. Do you experience any of the following:
    - a. Aching /pain in your legs 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. Bleeding from varicose Veins Yes______ No______

11. Do you experience these problems in one or both legs one _____ Left____ or right____ or Both______?
12. Have your varicose veins become worse in recent months Yes _____ No_______
13. Do you take medication or have you ever taken medication for leg pain Yes______ No________
(Example Advil, Ibuforen, etc) if yes what medication and how often to you take them? _______________

____

14. Do you elevate your legs to relieve discomfort? Yes_______ No________
15. Do you wear support hose or compression hose prescribed by a physician? Yes_______ No________
    If yes what type and how long have you worn____
16. Do you wear light support hose (e.g., sheer energy)? Yes_______ No________
17. Do they provide relief? Yes_______ No________
18. Do you have problems walking? Yes_______ No________
    If yes, how does it affect you____
19. Do you do a lot of standing on your job? Yes_______ No________
    At Home? Yes_______ No________
20. Have you had any tests done on your veins? Yes_______ No________
    If yes, when____
    What type of test? ____
    Where on your leg____
    Name of physician or clinic ____________________________________
21. Were you diagnosed with saphenous vein reflux? Yes_______ No________
22. How long have you been bothered with pain in your leg (s) ______________________________________
23. Are you pregnant or trying to get pregnant? Yes_______ No________

Thank you.

The North Florida Vein Clinic
2140 Kingsley Avenue, Suite #13
Orange Park, FL 32073
TEL 904-276-9222
FAX 904-276-7559