ADVANCED VASCULAR Vein Care
AdvancedVascular.com

**Main Phone: (973) 540-9700**
**Fax: (973) 540-9717**

# VEIN HISTORY FORM

**(CIRCLE ALL THAT APPLY TO YOUR HISTORY):**

PATIENT NAME: _____DOB:_____TODAY'S DATE: _____

## VEIN MEDICAL HISTORY

| | | |
|---|---|---|
| DVT (Blood clot in the leg) | ☐ RIGHT LEG | ☐ LEFT LEG |
| Phlebitis | ☐ RIGHT LEG | ☐ LEFT LEG |
| Leg/Ankle ulcers | ☐ RIGHT LEG | ☐ LEFT LEG |
| Vein removed for cardiac or leg bypass surgery | ☐ RIGHT LEG | ☐ LEFT LEG |
| Bleeding problems | ☐ RIGHT LEG | ☐ LEFT LEG |
| Blood clots | ☐ RIGHT LEG | ☐ LEFT LEG |
| Pulmonary Embolus (Blood clot in the lung) | ☐ YES | ☐ NO |

## VEIN TREATMENT HISTORY:

| | | |
|---|---|---|
| Endovenous Laser / Closure / Ablations | ☐ RIGHT LEG | ☐ LEFT LEG |
| Venous Stripping Surgery | ☐ RIGHT LEG | ☐ LEFT LEG |
| Sclerotherapy / Injection Treatment | ☐ RIGHT LEG | ☐ LEFT LEG |
| Phlebectomy (Varicose vein removal) | ☐ RIGHT LEG | ☐ LEFT LEG |
| Vein Surgery (unknown type) | ☐ RIGHT LEG | ☐ LEFT LEG |

## ADDITIONAL QUESTIONS:

1. Have you tried compression support stockings? ☐ YES ☐ NO
   a. If yes, how long did you try wearing the stockings? _____
2. Have you taken any pain medication for leg pain? ☐ YES ☐ NO
   a. If yes, how long have you been taking pain medication? _____
3. Do your daily activities require prolonged periods of standing? ☐ YES ☐ NO
4. Do you have a history of falls? ☐ YES ☐ NO
5. Are you currently pregnant or planning to become pregnant? ☐ YES ☐ NO
   # Pregnancies_____
6. Are you currently breast feeding? ☐ YES ☐ NO
7. Have you had a recent venous doppler or ultrasound of your legs? ☐ YES ☐ NO
   a. If yes, when / where? _____

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## REFERRAL INFORMATION

_____ _____
**PATIENT NAME (please print)** **Today's Date**

_____ _____
**PRIMARY CARE DOCTOR** **PRIMARY CARE DOCTORS ADDRESS**

We want to know how you heard about us!

Please check off the one best answer:

_____Referred by your doctor

Name of referring doctor: _____

_____Website/Internet Search

_____Newspaper Advertisement

_____Brochure - Where did you get the brochure from: _____

_____One of our patients recommended us to you

Name of referring patient: _____

_____Other – Please specify: _____

Thank you for choosing Advanced Vascular Vein Care!

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