

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **VEIN HISTORY**

Do you have or ever had leg swelling? \_\_\_ YES \_\_\_ NO

Do you have or ever had leg pain? \_\_\_ YES \_\_\_ NO

- Does it interfere with daily activities? \_\_\_ YES \_\_\_ NO

Do you have a history of vein stripping? \_\_\_ YES \_\_\_ NO

Do you take blood thinners? \_\_\_ YES \_\_\_ NO

Do you take Motrin, Advil, Tylenol, and/or Aspirin? \_\_\_ YES \_\_\_ NO

Do you have a history of surgery of your legs? \_\_\_ YES \_\_\_ NO

Do you have a or ever had a blood clot or phlebitis \_\_\_ YES \_\_\_ NO

Is there a history of heat, black and blue marks, or  
varicose veins of the legs? \_\_\_ YES \_\_\_ NO

Do you elevate your legs when resting? \_\_\_ YES \_\_\_ NO

Do you have a history of sudden onset of difficulty  
Breathing? \_\_\_ YES \_\_\_ NO

Do you have a history of smoking, high cholesterol, diabetes? \_\_\_ YES \_\_\_ NO

Have you ever worn compression stockings? \_\_\_ YES \_\_\_ NO

When: \_\_\_\_\_

How Long Worn: \_\_\_\_\_

What compression: \_\_\_\_\_