



Pueblo Radiology Medical Group

PATIENT VENOUS HISTORY

Patient Name: _____ **Date of Birth** _____

1. Have you had any previous treatment for varicose/spider veins? Yes No
 Dates of treatment _____
 Type of agent(s) used if known _____
2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis? Yes No
3. Do you have a family history of varicose/spider veins? Yes No
 If so, relationship(s) to you? _____
4. Are you currently, or have you been on any hormone therapy or birth control pills? Yes No
 If so, please list _____
5. Have you had any pregnancies? If so, how many: _____ Yes No
 If so, did your varicose/spider veins increase after pregnancies? Yes No
6. Do you wear support hose? Yes No
 If yes, are they prescription or over the counter? _____
7. Are you presently employed? If so, type of job _____ Yes No
8. Do you sit or stand for long periods of time? Hours per day? ___ Yes No
9. Do you take any pain medication for your varicose/spider veins: Yes No
 (Aspirin/Tylenol)
10. Do you elevate your legs to relieve your symptoms? Yes No
 If so, does it work?
11. Do you have any medication allergies? Yes No
 If so, please list _____

Additional History _____

COMPREHENSIVE HISTORY CHECK LIST (please check all that apply)

	Right Leg	Left Leg
Edema	_____	_____
Pain	_____	_____
Tiredness	_____	_____
Ulceration	_____	_____
Skin Color Changes	_____	_____
Spider Veins	_____	_____
Varicose Veins	_____	_____

Patient Signature _____ Date _____