TAYLOR VEIN SOLUTIONS

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Venous Evaluation Form – New Patient

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

Referring Physician: _____

What is your main concern today?:

_____

_____

Comprehensive History Check List (please check all that apply.)

	Right leg	Left leg	Comments:
Swelling	☐	☐	
Pain	☐	☐	
Tiredness/Heaviness	☐	☐	
Ulceration/Skin Breakdown	☐	☐	
Spider Veins	☐	☐	
Varicose Veins	☐	☐	

How long have you been concerned about your veins? _____ mo _____ years

Are your veins getting worse? YES NO

Did your trouble veins develop during pregnancy? YES NO

Have you had any previous treatment for varicose and or/spider veins? YES NO

If yes: Where, and type of treatment? _____

Do you have any history of ulceration (open areas on your skin) YES NO

Do you have any history of clots in your veins? YES NO

Do you elevate your legs to relieve your symptoms? YES NO

If yes, does it work? YES NO

Do you currently wear or have you worn compression stockings? YES NO

If yes, When Dates:

How long _____ mo _____ years

Does it work? YES NO

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Do you take any pain medication (include Tylenol, Aspirin, Motrin, etc.) for your varicose/spider veins? YES NO

If yes, name of medication/s _____

Are you presently employed? YES NO

Do you sit or stand for long periods of time? YES NO

If yes, how many hours per day? _____