ARLINGTON VASCULAR OFFICE

F. JON SENKOWSKY, MD, FACS – HEATHER SCHUSTER, PA-C

VENOUS HEALTH HISTORY FORM

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

Please answer the following questions & provide estimated date of occurrence….

PAST MEDICAL HISTORY

1. HAVE YOU EVER HAD VEIN STRIPPING SURGERY? YES ____ NO___
   IF YES, WHEN & WHICH LEG? _____
2. HAVE YOU EVER HAD VEIN INJECTIONS? YES____ NO____
   IF YES, WHICH LEG & WHERE ON THE LEG? _____
3. HAVE YOU EVER HAD A BLOOD CLOT? YES____ NO____
   IF YES, WHICH LEG & WHEN? _____
4. HAVE YOU EVER HAD PHLEBITIS? YES___ NO___
   IF YES, WHICH LEG & WHEN? _____
5. PLEASE LIST THE SIGNS & SYMPTOMS YOU HAVE EXPERIENCED (I.E., TROUBLE WITH WALKING, SWELLING, PAIN, ETC.
   _____
6. HAVE YOUR VEINS WORSENED IN RECENT MONTHS? YES___ NO___
   IF YES, DESCRIBE: _____
7. ARE YOU CURRENTLY TAKING PAIN MEDICATIONS? (I.E. ADVIL, MOTRIN, ETC) YES___ NO___
   IF YES, LIST MEDICATIONS WITH DOSAGES & TIMES PER DAY:
   _____
8. DO YOUR VEIN PROBLEMS KEEP YOU FROM PERFORMING YOUR NORMAL DAILY ACTIVITIES? YES____ NO____
9. DO YOU ELEVATE YOUR LEGS TO RELEIVE DISCOMFORT? YES___ NO___
   IF YES, HOW LONG PER DAY? _____
10. DO YOU WEAR PRESCRIPTION COMPRESSION HOSE? YES___ NO___
    IF YES, WHAT TYPE & GRADIENT? HOW OFTEN? _____
11. DO YOU WEAR LIGHT SUPPORT HOSE? (I.E. SHEER ENERGEY) YES___ NO___
    IF YES, DO THEY PROVIDE RELEIF? _____
12. HAVE YOU EVER HAD ANY TESTS DONE ON YOUR VEINS? YES___ NO___
    IF YES, PLEASE DESCRIBE: _____