

**Dr. Surya Challa MD PC**  
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**Venous Health History**

**A. Venous Health History Form**

Patient please complete questions 1-12

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Directions: Please answer the following questions. Provide estimates for date of occurrence.**

**Past Medical History**

1. Have you ever had vein stripping surgery  Yes  No  
 If yes, when and which leg? \_\_\_\_\_
2. Have you ever had vein injections?  Yes  No  
 If yes, which leg and where on the leg? \_\_\_\_\_
3. Have you ever had a blood clot?  Yes  No  
 If yes, which leg and when? \_\_\_\_\_
4. Have you ever had phlebitis?  Yes  No  
 If yes, which leg and when? \_\_\_\_\_
5. Have you ever had any bypass surgery?  Yes  No  
 If yes, which leg and when? \_\_\_\_\_

**Family History**

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Father     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

1. Do you experience any of the following in your legs?
 

Aching/pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Heaviness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Tiredness/fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Itching/burning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Swollen ankles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Leg cramps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Restless legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Throbbing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Other? _____				
2. Have your veins gotten worse in recent months?  Yes  No  
 Describe: \_\_\_\_\_
3. Do you take any medication for pain (i.e., Advil, Motrin)  Yes  No

If yes, what medication do you take and how many times/mgs per day? \_\_\_\_\_

4. Do you elevate your legs to relieve discomfort?  Yes  No  
If yes, how long per day do you elevate and does it provide relief? \_\_\_\_\_

**Venous Health History Form (cont.)**

5. Do you exercise?  Yes  No  
If yes, what kind of exercise and how often? \_\_\_\_\_

6. Do you wear prescription compression stockings?  Yes  No  
**If yes, what type and gradient? How long have you worn them?** \_\_\_\_\_

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? \_\_\_\_\_

7. Do you wear light support hose (i.e., Sheer Energy)?  Yes  No  
If yes, do they provide relief?  Yes  No

8. Do you have any problem walking?  Yes  No  
If yes, describe how it interferes with your activities of daily living, which activities? \_\_\_\_\_

9. What type of work do you do? \_\_\_\_\_  
How long do you stand (hours per day) at work? \_\_\_\_\_ At home? \_\_\_\_\_  
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: \_\_\_\_\_

10. Have you ever had any test(s) done on your veins?  Yes  No  
If yes, when and what type of test and where on the leg? \_\_\_\_\_

11. Were you diagnosed with saphenous vein reflux?  Yes  No

12. Name of referring Physician and how long have you been under his care for treatment of this condition? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENTS: Please stop here. The physician may go over additional questions with you.**