4545 Highway 17 Bypass, Suite A • Murrells Inlet, SC 29576 • 843-652-LEGG (5344)

HISTORY SHEET

Name: ________________________ Date: ____________ Age: ______ Ht.: _____ Wt: _____

-When did you first notice your enlarged or discolored veins: ____________________

Which leg bothers you the most? ☐ Right ☐ Left ☐ Both

What symptoms are you having?

1. Sharp pain . . . . Yes No
2. Dull pain . . . . Yes No
3. Aching Legs. . . . . . Yes No
4. Swelling . . . . Yes No
5. Itching . . . . Yes No
6. Leg Ulcers . . . . Yes No
7. Tiredness . . . . Yes No
8. Burning . . . . Yes No
9. Heaviness. . . . . Yes No
10. Cramps. . . . . Yes No
11. Throbbing . . . . Yes No
12. Restless Legs . . . . . Yes No
13. Appearance . . . . . . Yes No

Do your symptoms interfere with your daily activities? ☐ Yes ☐ No

Have you ever used compression hose? ☐ Yes ☐ No If yes, how long? ____________

Have you ever had:

1. Phlebitis (clots in legs) . . . . ☐ Yes ☐ No When ____________
2. Deep Vein thrombosis. . . . . ☐ Yes ☐ No When ____________
3. Pulmonary embolus (blood clot in lung) . . . ☐ Yes ☐ No When ____________
4. Leg or ankle ulcers . . . . ☐ Yes ☐ No When ____________
5. Painful varicose veins. . . . . ☐ Yes ☐ No When ____________
6. Venogram (Vein X-Ray) . . . . ☐ Yes ☐ No When ____________
7. An Ultrasound of your legs . . . . ☐ Yes ☐ No When ____________
8. Bleeding from your varicose veins. . . . . ☐ Yes ☐ No When ____________

Have you ever been pregnant? ☐ Yes ☐ No

How many times? ____________

How many deliveries? ____________

Are you presently pregnant? ☐ Yes ☐ No

List all medications you are currently taking (including aspirin if applicable)

____

____

List any hormones you may be taking: ____________________

Birth control pills: ☐ Yes ☐ No

List all allergies: ____________________

Have you had any adverse reactions with scars? ☐ Yes ☐ No

Are you able to walk for 20 minutes three time a day? ☐ Yes ☐ No

Have you ever had any of the following:

1. AIDS or HIV positive. . . . . ☐ Yes ☐ No
2. Diabetes. . . . . ☐ Yes ☐ No
3. Migraine Headaches . . . . ☐ Yes ☐ No

(Please continue on other side.)

Have you ever had any of the following:

4. High Blood Pressure . . . . ☐ Yes ☐ No
5. Heart Disease . . . . ☐ Yes ☐ No
6. Jaundice or Hepatitis. . . . . ☐ Yes ☐ No
7. Cancer . . . . ☐ Yes ☐ No
8. Recent Weight Change . . . . ☐ Yes ☐ No
9. Major Injury or surgery on your legs . . . . . . ☐ Yes ☐ No
10. Leg pain at night . . . . ☐ Yes ☐ No
11. Leg pain caused by walking . . . . ☐ Yes ☐ No
12. Leg pain caused by standing. . . . . ☐ Yes ☐ No
13. Clotting or blood problems. . . . . ☐ Yes ☐ No
14. Treatment for Varicose or spider Veins . . . . ☐ Yes ☐ No

Have you ever had sclerotherapy before? ☐ Yes ☐ No When

Have you ever smoked? ☐ Yes ☐ No Packs/Day_____ # Years _____

Are you currently smoking? ☐ Yes ☐ No Packs/Day_____ # Years _____

List any and all family members with vein problems:

____

____

Who can we thank for referring you to our office?________________________________

How did you hear about us? ☐ Billboard ☐ Internet / Website ☐ Friend ☐ Doctor
☐ Phone Book ☐ Newspaper ad ☐ Radio ☐ Other

<u>FOR DOCTOR USE ONLY</u>

Movie seen ☐ Yes ☐ No
Telangiectasias: ☐ Right ☐ Left Severity____________________
Reticulars: ☐ Right ☐ Left Severity____________________
Varicose Veins ☐ Yes ☐ No Severity____________________

*V.V. Size______________ mm
*SFJ ☐ Right ☐ Left
*SPJ ☐ Right ☐ Left

PPG ☐ Yes ☐ No ☐ Right ☐ Left ☐ Ven ☐ Art ☐ Both
U.S ☐ Yes ☐ No ☐ Right ☐ Left
Appt. for Sclero: ☐ Yes ☐ No