



# Rocky Mountain SURGICAL SOLUTIONS

2831 Fort Missoula Road, Building #2, Suite 104, Missoula, Montana 59804  
Ph. 406.728.0285, Fax. 406.728.0613 www.rockymountainsurgicalsolutions.com

## Patient Venous History

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Have you had any previous treatment for varicose/spider veins (ex: vein stripping or Sclerosing)? Yes No  
Date(s) of treatment: \_\_\_\_\_ Type of agent(s) used if known: \_\_\_\_\_

Have you ever had any vein injections? Yes No  
If yes, which leg and where on the leg? \_\_\_\_\_ Yes No

Do you have any history of ulcerations, clots in the veins, deep vein thrombosis, or phlebitis? Yes No

Do you have a family history of varicose/spider veins? Yes No  
If so, relationship(s) to you: \_\_\_\_\_

Are you currently or have you been on any hormone therapy or birth control pills? Yes No  
If so please list: \_\_\_\_\_

Have you had any pregnancies? If so, how many? \_\_\_\_\_ Yes No  
If so, did your varicose/spider veins increase after your pregnancies? Yes No

Have you worn compression stockings? Yes No  
If yes, are they prescription or over the counter? : \_\_\_\_\_  
If so, how long have you worn them? : \_\_\_\_\_

Are you presently employed? Yes No  
If so, what type of job? : \_\_\_\_\_

Do painful varicose veins interfere with your job? Yes No

Do you sit or stand for long periods of time? Yes No  
How many hours per day? \_\_\_\_\_

Do you take any pain medication for your varicose/spider veins (Aspirin/Tylenol)? Yes No  
If so, how often: \_\_\_\_\_ How much: \_\_\_\_\_

Do you elevate your legs to relieve your symptoms? Yes No  
If so, does it work? Yes No

Do you have severe or persistent pain interfering with activities of daily living? Yes No

Do you exercise? If so, how often: \_\_\_\_\_ Yes No

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

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

	Left	Right	Both		Left	Right	Both
Edema (Fluid accumulation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin color changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spider Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>