

Hastings Surgeons, P.C.

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Hastings, MI 49058
(269) 948-8411

VNUS Health History Form

Patient Name: _____

Date of Birth: _____

Regular Physician: _____

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

Aching / pain?	Yes_____	Left_____	Right_____
Heaviness	Yes_____	Left_____	Right_____
Tiredness / fatigue?	Yes_____	Left_____	Right_____
Itching / burning?	Yes_____	Left_____	Right_____
Swollen ankles?	Yes_____	Left_____	Right_____
Leg cramps?	Yes_____	Left_____	Right_____
Restless legs?	Yes_____	Left_____	Right_____
Throbbing?	Yes_____	Left_____	Right_____
Ulcer formation?	Yes_____	Left_____	Right_____
Unna boot use?	Yes_____	Left_____	Right_____
Other?	_____		

2. Have your veins gotten worse in recent months? Yes_____ No_____

Please describe:

3. Do you take any medication for pain (i.e., Advil, Motrin)? Yes_____ No_____

Please list:

4. Do you elevate your legs to relieve discomfort? Yes_____ No_____

How long per day _____ Does it provide relief? Yes_____ No_____

5. Do you exercise? Yes_____ No_____

What kind of exercise and how often?

6. Do you wear compression stockings? Yes_____ No_____

7. Do you have any problem walking? Yes_____ No_____

If yes, describe how it interferes with your activities of daily living, which activities?

8. What type of work do you do?

How long do you stand (hours per day) at work? _____ At home? _____

Are your symptoms interfering with your essential job function of your specific occupation, which activities?

Past Medical History

1. Have you ever had any tests done on your veins? Yes _____ No _____

Please describe:

Were you diagnosed with saphenous vein reflux? Yes _____ No _____

2. Have you ever had vein stripping surgery? Yes _____ No _____

If yes, when and which leg?

3. Have you ever had vein injections? Yes _____ No _____

If yes, which leg and where on the leg?

4. Have you ever had a blood clot? Yes _____ No _____

If yes, which leg and where on the leg?

Family History

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

Mother _____ Father _____ Brother(s) _____ Sister(s) _____

Other _____

Permission to Photograph

I do hereby authorize Hastings Surgeons, PC to photograph and use my photograph for the purpose of medical, scientific or educational purposes.

Patient Signature _____ Date _____