



Deak Vein NJ Clinic

In Office Laser Vein Treatment
In Office Laser Vein Treatment

PATIENT VENOUS HISTORY

Patient Name _____

Date of Birth

1. Have you had any prior treatment for varicose/spider veins? YES NO
Date(s) of treatment _____
Type of agent(s) used, if known _____
2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis? YES NO
3. Do you have a family history of varicose/spider veins? YES NO
If so, relationship(s) to you _____
4. Are you currently, or have you been on any hormone therapy of birth control pills? YES NO

If so, please list _____

- | | | |
|-------------------------------------------------------------------------------------------|-----|----|
| 5. Have you had any pregnancies? If so, how many? _____ | YES | NO |
| If so, did your varicose/spider veins increase after your pregnancies? | YES | NO |
| 6. Do you wear support hose? If yes, are they prescription or over-the-counter? | RX | OC |
| 7. Are you presently employed? If so, type of job _____ | YES | NO |
| 8. Do you sit or stand for long periods of time? How many hours per day? _____ | YES | NO |
| 9. Do you take any pain medications for your varicose/spider veins (Aspirin/
Tylenol)? | YES | NO |
| 10. Do you elevate your legs to relieve your symptoms? | YES | NO |
| If so, does it work? | YES | NO |
| 11. Have you received and read the Sclerotherapy brochure? | YES | NO |

Additional History _____

COMPREHENSIVE HISTORY CHECKLIST

(Please check all those that apply)

	Right Leg	Left Leg
Edema		

Pain

Tiredness

Ulceration

Skin Color Changes

Spider Veins

Varicose Veins

Patient Signature _____

Date