

**CENTRAL TEXAS VEIN CENTER
CURRENT HISTORY**

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|-------------------------------|-----|----|
| 1. Do you have heart disease? | Yes | No |
| Lung disease? | Yes | No |
| High blood pressure? | Yes | No |
| Arthritis? | Yes | No |
| Diabetes? | Yes | No |
| Other? _____ | | |

2. Do you have any allergies (medicines, food, latex, or tape)? Yes No
- If yes, what allergies? _____

3. Please list all medications you are taking including over-the-counter _____
- _____
- _____

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|---|-----|----|
| 4. Do you experience any of the following with your legs? | | |
| Aching/pain | Yes | No |
| Heaviness | Yes | No |
| Tiredness/fatigue | Yes | No |
| Burning/numbness/tingling | Yes | No |
| Cramping/throbbing | Yes | No |
| Swollen ankles | Yes | No |
| Restless legs | Yes | No |
| Night cramps | Yes | No |
| Itching | Yes | No |

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|--------------------------------|-----|----|
| 5. Do you have varicose veins? | Yes | No |
| Spider veins? | Yes | No |
| If yes, for how long? _____ | | |

6. Have your legs gotten worse in recent months? Yes No

7. How long have you had leg discomfort? _____

8. What methods do you use to relieve your leg discomfort? (Check all that apply below)
- Compression stockings/support hose ____
If yes, how long have you worn them? _____
Do they help? _____
 - Leg elevation ____ Aspirin ____
 - No discomfort ____ Tylenol ____
 - Exercise ____ Ibuprofen ____
 - Walking ____ Pain meds ____
 - Warm socks ____ Cold packs ____
 - Other methods _____