Mon Health℠ Vein Care
A service of Mon Health Medical Center

Date:_____

Name:_____DOB:_____

Circle all that apply:

Pain	Pressure	Throbbing
Swelling	Numbness	Itching/Burning
Restless Legs	Tiredness/Heaviness	Bleeding Veins
Cramping	Hyper pigmentation	Aching
Cramping	Spider veins	Cellulitis

How long have you had this problem?_____

History of healed or active wounds or ulcers? Yes or No (if yes please explain)_____

History of blood clots? DVT Phlebitis PE No history

Personal or family history of clotting disorder? Yes or No

Hormone replacement therapy? Yes or No
How Long?_____

Number of pregnancies?_____ N/A

Occupation:_____

Does your job or activities involve:
-Heavy Lifting > 10 lbs -Pulling > 10 lbs
-Prolonged standing ____hrs or prolonged sitting ____hrs

How many hours each day spent on feet?_____

Do you take Aspirin, Coumadin, Plavix, Pradaxa or any other blood thinner? Yes or No

Do you take pain meds for your symptoms?
OTC; Tylenol, Motrin, Advil, Ibuprofen, Aleve or RX_____
How long?_____

Does elevation help relieve symptoms? Yes or No

Have you worn prescription compression in the past? Yes or No

What type? OTC; TED; Jobst; compression wraps; Other_____

How long? 2-4 weeks; 6-8 weeks; 1-2 months; 3-6 months; >6 months

Has the patient had vein procedures in the past?
(For example:vein injections or stripping or ligations) Yes or No
If yes when and where?_____

Medications:

Drug:	Dose:	How often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies and reaction:_____

May we send a follow up letter regarding evaluation to PCP? Yes or No
Dr_____ City_____ State_____