WILLAMETTE
VASCULAR SPECIALISTS, P.C

History for Venous Disease

Your Name:_____ **Date of Birth**_____

Please answer the following questions as completely as you can.

Are you seekng treatment for:

Cosmetic reasons (solely for improvement of appearance) _____
Medical reasons (relief of pain, swelling, aching or cramps) _____

General Vascular History
Please indicate which of these problems you have had:

Pain in your:	**Right Leg**	**Left Leg**	**How many years**
Thigh	_____	_____	_____
Calf	_____	_____	_____
Leg	_____	_____	_____
Swelling:	_____	_____	_____
Skin or ulcer Problems	_____	_____	_____

Other:
Please specify _____

If you experience pain in your lower limbs, please circle yes or no, as applicable.

Is the pain made worse by:

Extended periods in standing position	yes	no
Heat	yes	no
Menstrual periods	yes	no
Exercising and/or walking	yes	no
Medication	yes	no
Other	yes	no

Please specify: _____

Does the pain decrease if you :

Elevate your legs	yes	no
Walk and/or exercise	yes	no

What type of pain do you have?

Resting pain	yes	no	Tiredness in your legs	yes	no
Resting cramps	yes	no	Heaviness in your legs	yes	no
Night cramp	yes	no	Numbness	yes	no
Other	yes	no	Burning sensation	yes	no

Please specify: _____

Are you pregnant or planning to become pragnant soon? yes no