



Lake Medical Imaging & Vascular Institute

Accredited by the American College of Radiology

Leg Vein History

Name _____

What is the reason why you are seeking treatment? **Cosmetic** **Medical**

Have you seen any other doctors for treatment of your veins? **Yes** **No**
If yes, please explain:

Do you or have you ever worn compression stockings? **Yes** **No**

Do/did they help you? **Yes** **No**

Do you experience any of the following symptoms in your legs?

Aching/Pain	Yes	No
Heaviness	Yes	No
Tiredness/Fatigue	Yes	No
Itching/Burning	Yes	No
Swollen Ankles	Yes	No
Leg Cramps	Yes	No
Throbbing	Yes	No
Restless Leg	Yes	No

Are there any other leg symptoms?

Do you have a problem walking? **Yes** **No** **If yes, please explain:**

Are your symptoms worse at the end of the day?

Are the problems that you are having in your legs interfering with your lifestyle?
