



Lake Medical Imaging & Vascular Institute

A Clearer Vision

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 (please circle)?

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

Are there any other leg symptoms? Yes _____ No _____ If yes, please explain:

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

Are your symptoms worse at the end of the day? Yes _____ No _____

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

