RCI Radiology Consultants of Iowa, PLC Vein & Interventional Clinic

VEIN AND INTERVENTIONAL CLINIC
VENOUS HISTORY

NAME _____ **DATE**_____

Which leg is symptomatic? **Right** **Left** **Both**

How long have you had symptoms with your veins? _____

SYMPTOMS (check all that apply)

- ☐ Spider veins
- ☐ Varicose veins
- ☐ Tired/ heavy legs
- ☐ Aching/throbbing
- ☐ Tenderness
- ☐ Swelling
- ☐ Pain
- ☐ Burning/itching
- ☐ Cramping
- ☐ Red/warm areas
- ☐ Skin changes
- ☐ Deep venous thrombosis
- ☐ Pulmonary embolus
- ☐ Bleeding from varicosity
- ☐ Superficial phlebitis
- ☐ Ulcers or ulcerations

ARE YOUR SYMPTOMS

yes no Related to pregnancy?
yes no Related to accident/trauma?
yes no Are you developing new veins?

DO YOUR SYMPTOMS GET WORSE WITH

yes no Prolonged standing
yes no Prolonged sitting
yes no Menstrual cycle

Do your symptoms improve with elevation? yes no

Do your symptoms interfere with your daily activities? yes no
If yes, explain how: _____

_____

PREVIOUS CONSERVATIVE TREATMENT YOU HAVE TRIED

Have you ever worn compression stockings? yes no How long? _____
Doctor who prescribed stockings for you. _____
Did the stockings help your symptoms? yes no

Do you take over the counter medication for leg pain?
(i.e. ibuprofen, Motrin, Advil, Tylenol, aspirin) yes no Medication _____

PREVIOUS TREATMENT HISTORY

yes no Ligation / stripping surgery Which leg? Right Left When? _____
yes no Injection treatments / sclerotherapy Which leg? Right Left When? _____
yes no Laser therapy / EVLT Which leg? Right Left When? _____

What is your goal in treating your veins?_____

_____

How did you hear about the Vein Clinic at RCI? ☐ Dr ☐ TV ☐ Family/Friends ☐ Internet ☐ Radio __ KMRY or __96.5

PATIENT SIGNATURE:_____ **DATE:** _____

RCI Imaging Center ·1948 First Avenue NE Cedar Rapids, IA 52402
Ph 319-261-0636 · Fax 319-364-5684 · www.RCIowa.com