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**PATIENT VENOUS HEALTH HISTORY FORM**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: M\_\_\_ F\_\_\_

*Directions: Please answer the following questions, trying not to leave any blank spaces.*

1. Have you ever had any vein stripping surgery? YES NO

If yes, when and which leg?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Have you ever had vein injections? YES NO

If yes, when, and which leg?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Are you presently under the care of a physician? YES NO

If yes, for what illness or purpose?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Have you ever had a blood clot? YES NO

If yes, which leg and when? \_\_\_\_\_

5. Have you ever had phlebitis? YES NO

If yes, which leg and when? \_\_\_\_\_

**FAMILY**

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

Father	YES	NO
Mother	YES	NO
Brother(s)	YES	NO
Sister(s)	YES	NO
Other _____		

1. Do you experience any of the following?

a. Aching/pain in your legs? YES NO

