

Thomas R. Bernik, M.D.
Vascular and Endovascular Surgery
Interventional Radiology and
Cosmetic Vein Surgery

Venous History

Patient Name: _____

Date: _____

Problem: _____

Progression/Complications: _____

Current Medications: _____

Allergies: _____

(Mark all that apply)

Symptoms:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> throb / aches | <input type="checkbox"/> heavy / full | <input type="checkbox"/> pain | <input type="checkbox"/> cramping |
| <input type="checkbox"/> itch | <input type="checkbox"/> burning / sting | <input type="checkbox"/> swell | <input type="checkbox"/> bleed |
| <input type="checkbox"/> pelvic symptoms | <input type="checkbox"/> easy bruise | <input type="checkbox"/> muscle fatigue | <input type="checkbox"/> leg restlessness |
| <input type="checkbox"/> I am able to walk 1 mile without symptoms | | <input type="checkbox"/> other: _____ | |

Worse:

- | | | | |
|---|----------------------------------|---|-------------------------------|
| <input type="checkbox"/> standing | <input type="checkbox"/> sitting | <input type="checkbox"/> walking/exercise | <input type="checkbox"/> heat |
| <input type="checkbox"/> pre-menstrual | night | | |
| <input type="checkbox"/> worsening of symptoms with pregnancy | | <input type="checkbox"/> other: _____ | |

Better:

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> elevation | <input type="checkbox"/> exercise | <input type="checkbox"/> coolness | <input type="checkbox"/> Elastic Compression |
| <input type="checkbox"/> elastic compression garment: how long? _____ | | <input type="checkbox"/> other: _____ | |
| <input type="checkbox"/> medications: _____ | (Advil / Aspirin / Aleve / Anti-inflammatory / Tylenol / Motrin / Naprosyn) | | |

Previous Treatment:

- | | | |
|---|---|-------------|
| Surgery: <input type="checkbox"/> stripping – Right leg | <input type="checkbox"/> stripping – Left leg | Date: _____ |
| <input type="checkbox"/> ligation – Right leg | <input type="checkbox"/> ligation – Left leg | Date: _____ |

Injections: Right leg Left leg Date: _____

Laser: Right leg Left leg Date: _____

Results: _____

Comments: _____

(patient signature)

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