EVLT____________ Mini_________

Clarivein__________rt____________lt

Venaseal__________rt____________lt

VENOUS ASSESSMENT FORM

Name________________________________ Date______________________________

Health card number______________________ Date of Birth________________________

Address______________________________ City_______________ Province______

Postal Code_______ E-mail_____________________________

Phone Number__________________________ Cell/Phone__________________________

Family Doctor___________________________

Please circle all that apply;

COMPLAINTS: Lower / Upper Extremity Both / Right / Left Duration _____ yrs / mo / wks / days

___ aching/des douleurs
heaviness/de la lourdeur

___itching/des demangeaisons
burning/une sensation de brulure

___eczema/l'eczema
leg ulcers/ une ulceration des jambes

___numbness, weakness

___pain/des douleurs

___tiredness,fatigue

___easy bruising

___foot pain

___leg cramps/des crampes

___swollen legs/ankles/
des jambs enflees

___restless legs/des jambes
agitees

___problems walking
___COSMETIC REASONS

Are your symptoms worse at the end of the day?	Yes	No	
Are your leg problems interfering with your lifestyle?	Yes	No	
Are your problems worse during your menstrual period?	Yes	No	N/A
Have you ever worn compression stockings?	Yes	No	

PAST HISTORY:

Have you ever had superficial thrombophlebitis?	No	Yes ______________________
Have you ever had blood clots in your legs?	No	Yes ______________________
Do members of your immediate family have varicose veins?	No	Yes ______________________
Have you seen any other doctor for treatment of your veins?	No	Yes ______________________

If yes, please detail which DR / Clinic / dates / treatment received:

Previous Venous Procedures: ___ Stripping ___ Sclerotherapy ___ Ligation ___ Phlebectomy ___ Laser

Work Situation: ___ Sitting most of the time ___ Standing / walking ___ Standing in one place all the time

Number of Full-term Pregnancies: _______________ Hormone Pills: ___ No ___ Yes

MEDICAL HISTORY:

Have you had significant illnesses:
____

__ Hypertension	__ Heart Disease	__ Diabetes	__ Thyroid Disease
__ Headaches	__ Visual Disturbances	__ Weight Gain	__ Asthma
__ Bronchitis	__ Peptic Ulcer	__ Bowel Disease	__ Kidney Disease
__ Hepatitis	__ Liver Disease	__ Breast Disease	__ Bleeding disorders
__ Blood Clots	__ Epilepsy	__ Arthritis	__Others

SURGICAL HISTORY:

Year: ________________ Illness or operation:
____

Year: ________________ Illness or operation:
____

Year: ________________ Illness or operation:
____

Year: ________________ Illness or operation:
____

Any complications with General or Local Anesthesia: YES / NO / Blood Transfusions: YES / NO

MEDICATIONS:
____

____

BLOOD THINNER? (ASPIRIN, WARFARIN, etc) YES / NO If Yes, what product?____

ALLERGIES:
____

How did you hear about Canada Vein Clincs? (please circle and/or fill out)

Internet	**Referred by A Friend**	**GP or Doctor**	**Canada Vein Clinic Ad**(where did you see it)
Google	Name_________________	Name______________	News Paper ________________
Facebook			Flyer______________________
Instagram			Brochure___________________
Other______________			Other______________________