RADIOLOGY
IMAGING ASSOCIATES P.C.
ENDOVASCULAR

Venous Evaluation Form - New Patient

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RIAEndovascular.com

Patient Name _____ Date of Birth _____

Your Main Concern Today _____ Referring Physician _____ ☐ N/A

History _____

_____

_____

_____

Comprehensive History Checklist - Please check all that apply.

	Right Leg	Left Leg	Comments
Swelling	☐	☐	_____
Pain	☐	☐	_____
Tiredness/Heaviness	☐	☐	_____
Ulceration Location - Skin Breakdown	☐	☐	_____
Skin Color Changes	☐	☐	_____
Spider Veins	☐	☐	_____
Varicose Veins	☐	☐	_____

How long have you been concerned about your veins? _____ mo _____ years

Are your veins getting worse? Yes ☐ No ☐

If applicable: Did your troublesome veins develop during a pregnancy? NA ☐ Yes ☐ No ☐

Have you had any previous treatment for varicose and/or spider veins? Yes ☐ No ☐

If yes: Type of treatment _____

Agent(s) used (if known) _____

Do you have any history of ulcerations (open areas on your skin)? Yes ☐ No ☐

Do you have any history of clots in your veins? Yes ☐ No ☐

Do you elevate your legs to relieve your symptoms? Yes ☐ No ☐

If yes, does it work? Yes ☐ No ☐

Do you currently wear, or have you ever worn, compression stockings? Yes ☐ No ☐

If yes, when? Dates: _____

How long? _____ mo _____ years

Does it work? Yes ☐ No ☐

Do you take any pain medication (including Tylenol, Aspirin, Motrin, etc.) for your varicose/spider veins? Yes ☐ No ☐

If yes, name of medication/s _____

Are you presently employed? Yes ☐ No ☐

Do you sit or stand for long periods of time? Yes ☐ No ☐

If yes, how many hours per day? _____

Do your leg symptoms impact your daily activities at work or at home? Yes ☐ No ☐

If yes, how? _____

Do you avoid doing any activities due to your leg symptoms? Yes ☐ No ☐

If yes, what? _____

For office use only: ☐ Compression hose prescription given to patient ☐ Pre-procedure photos taken ☐ Post-procedure photos taken