Name:_____ DOB:_____ Phone:_____

CHECKLIST FOR VEIN APPOINTMENT

Have you been to our clinic before? ☐ Yes ☐ No

- If so, how long ago? _____

-What did you have done? _____

Are the veins flat, or do they bulge? _____

Do you have any pain? ☐ Yes ☐ No

- Is the pain only in that vein, ☐ Yes ☐ No

- or is pain all over the legs? ☐ Yes ☐ No

Do you have swelling? ☐ Yes ☐ No

Is there redness in skin around vein? ☐ Yes ☐ No

Is the condition getting worse? ☐ Yes ☐ No

Do you take pain medication for it? Advil, Tylenol etc.. ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____