PATIENT NAME (LAST, FIRST): ______________________ DOB (mm/dd/yyyy): ______________________

Review of Symptoms – Pelvic Venous

Please indicate if you have the following symptoms:

Pelvic Pain

- o Yes - If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): ____ /10
- o No

Pelvic Heaviness/Fullness sensation

- o Yes
- o No

Pelvic Bloating

- o Yes
- o No

Leg Pain/Achiness/Throbbing/Discomfort

- o Yes - If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): ____ /10
- o No

Leg Swelling/Edema

- o Yes
- o No

Swelling is onset (choose one option below):

- o During the day
- o During midday
- o During nighttime

Leg Heaviness

- o Yes
- o No

Urinary Urgency

- o Yes
- o No

Urinary Frequency (during daytime or nighttime)

- o Yes - If yes, please specify ____

- o No

Lower back pain

- o Yes
- o No

Do you experience pain during your menstrual cycle (if applicable?

- o Yes - If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): ____ /10
- o No

Do you experience pain during or after intercourse?

- o Yes - If yes, please describe the pain/sensation, how long it lasts and rate it out of 10 (0 being no pain, 10 being the worst pain): ____ /10
- o No

Do you experience/notice any bulging veins near the groin or vulvar area?

- o Yes - If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): ____ /10
- o No

Do you have any upcoming travel?

- o If yes, where? ____

Method of Travel (car, bus, train, plane) ____

- o No

Do you have any upcoming procedures?

- o Yes - Name of procedure(s): ____
- o No

PATIENT NAME (LAST, FIRST): ____________________ DOB (mm/dd/yyyy): ____________________

Please answer the following questions:

Have you ever been diagnosed with known spinal or back issues?

- Yes - Please explain: ____
- No

Do you wear compression socks/stockings or compression leggings/pantyhose?

- Yes - How many days a week do you wear them? ______________________________
- No

Have you ever been diagnosed with lymphedema?

- Yes
- No

Do you have a lymphedema pump?

- Yes - How many days a week do you use the pump? ___________________________
- No

Have you been seen by the Center for Vein Restoration (CVR)?

- Yes
- No

Have you ever undergone superficial vein treatment with CVR or another vein practice?

- Yes - If so, please explain: ____
- No

Have you ever been diagnosed with DVT (Deep Vein Thrombosis) or any blood clotting disorders?

- Yes - If so, please explain: ____
- No

Are you currently on any blood thinners (Aspirin, Plavix, Eliquis, Xarelto, Warfarin etc.)?

- Yes - If so, please explain: ____
- No