



Patient Supplement Sheet

Name (First, MI, Last): _____

How long have your vein problems existed? _____

Do your legs bother you? No____ Yes (explain): _____

Have you had treatment before for your veins? No___ Yes (check all that apply):_____

_____ Stripping or other surgery Date: _____

_____ Compression Stockings Date: _____

_____ Injections Date: _____

_____ RF Ablation Date: _____

_____ Laser Treatment Date: _____

Family history of varicose veins? _____

Have you had blood clots in your veins? No____ Yes (explain): _____
