Varicose Vein Questionnaire

NAME		
DOB	AGE	SEX
WHO IS YOUR PRIMARY CARE PHYSICIAN?		
NAME OF REFERRING PHYSICIAN:		

How did you hear about us?

☐ Website ☐ TV ☐ Physician ☐ Event
☐ Radio ☐ Friend ☐ Insurance List ☐ Other:

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1. Do you have any experience any of the following sensations in your legs? Please choose all that apply.

☐ Aching ☐ Heaviness ☐ Fatigue ☐ Burning
☐ Cramping ☐ Throbbing ☐ Pain ☐ Tiredness
☐ Itching ☐ Swelling ☐ Restless Legs ☐ Other:

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2. When did you first notice vein-related discomfort?

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3. How does your leg pain affect daily activities?

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4. Have your veins worsened in recent months? ☐ Yes ☐ No

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5. Does elevating your legs relieve your discomfort? ☐ Yes ☐ No

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6. Do you wear support/compression hose prescribed by a doctor? ☐ Yes ☐ No
   a. If yes, for how long? _____
   b. Do they provide relief? ☐ Yes ☐ No

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7. Have you ever had bleeding with your leg veins? ☐ Yes ☐ No

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8. Do you have any problem walking? ☐ Yes ☐ No

9. Have you ever had your veins evaluated? ☐ Yes ☐ No
    a. If so, when and where?

10. Have you ever had any tests done on your veins? ☐ Yes ☐ No

11. Have you ever had vein stripping or phlebectomy surgery? ☐ Yes ☐ No
    a. If so, when, where, and which leg?

12. Have you ever had sclerotherapy vein injections? ☐ Yes ☐ No
    a. If so, when, where, and which leg?

13. Have you ever had a blood clot? ☐ Yes ☐ No

14. Have you ever had phlebitis? ☐ Yes ☐ No
    a. If yes, when and which leg?

15. Have you had a venous stasis ulcer? ☐ Yes ☐ No