Vein Questionnaire

Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

Do you experience any of the following in your legs? Please check all that apply.

☐ ACHING	☐ THROBBING	☐ CRAMPING	☐ REDNESS
☐ WARMTH	☐ ULCER	☐ ITCHING	☐ HEAVINESSS
☐ FATIGUE	☐ TENDERNESS	☐ ANKLE SWELLING	☐ HARD LUMPS
☐ BURNING	☐ DISCOLORATION	☐ RESTLESS LEG	☐ NUMBNESS

Rate the intensity of pain:

No Pain		Mild Pain		Moderate Pain		Severe			Excruciating	
0	1	2	3	4	5	6	7	8	9	10

Is the pain persistent? ☐ Yes ☐ No

Tell us when your symptoms limit your activities of daily living to include occupational tasks, home life and lifestyle activities? (PLEASE SELECT AT LEAST ONE)

☐ WALKING	☐ DRESSING	☐ DRIVING	☐ PREPARING MEALS
☐ EXERCISE	☐ LIFTING	☐ LAUNDRY	☐ VACUUMING
☐ BATHING	☐ GROOMING	☐ WASHING DISHES	☐ SLEEPING
☐ SHOPPING	☐ RUNNING	☐ FAMILY/CHILD CARE	☐ PROLONGED STANDING/SITTING

Other: _____

How long have your legs been bothering you? _____

Have your veins worsened in recent months? ☐ Yes ☐ No
Describe: _____

Do you take any medication for pain (i.e., Advil, Motrin or other) ☐ Yes ☐ No
If yes, what medication(s) and how many times/MGs per day? _____

Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No Does it help? ☐ Yes ☐ No
If yes, how long per day do you elevate? _____

Do you exercise? ☐ Yes ☐ No Does it help alleviate symptoms? ☐ Yes ☐ No

Have you ever been diagnosed with venous reflux? ☐ Yes ☐ No Details: _____
Have you ever had a blood clot in your legs? ☐ Yes ☐ No Details: _____
Is there a family history of Varicose Veins: ☐ Yes ☐ No Family history of Blood Clots: ☐ Yes ☐ No
Which family member(s)? _____

Do you wear compression stockings? ☐ Yes ☐ No Have you worn them in the past? ☐ Yes ☐ No
What type? ☐ Knee High ☐ Thigh High Do they currently or did they previously provide relief? ☐ Yes ☐ No
How long have you or did you wear them? _____
If you have stopped wearing the hose, please state the reasons why:_____

Have you ever had any treatment(s) done on your veins? ☐ Yes ☐ No
If yes, when? _____
What type of treatment(s) and which leg? _____

Who is your primary care provider?_____
Have they treated you for this condition? ☐ Yes ☐ No For how long: _____

For Females:
How many children have you carried to delivery? _____
Did your veins worsen with pregnancy? ☐ Yes ☐ No
Have you noticed varicose veins in the pelvic area? ☐ Yes ☐ No
Do you have pelvic pain with standing, during menstruation, or with intercourse? ☐ Yes ☐ No

I acknowledge that the Ultrasound and Consultation, and any subsequent services, will be billed to my insurance and that these services are not part of the Free Vein Screening that I may have heard about or participated in previously. _____ (initials)

Patient Signature: _____ Date: _____