Douglas Vascular Center
Quality of Life Questionnaire

Patient Name: _____ D O B: _____ Date: _____

- Have you had any treatments for veins in your legs? If yes, please list the procedure, date of procedure, and preforming physician.
  _____
_____
_____
_____

- Have you had any bleeding from the veins? **Yes** **No** If yes, which Leg? **Left** **Right** **Both**

Where on the leg(s)?
_____
Was this a spontaneous bleed? (bleeding without any bumping, scratching, or trauma) **Yes** **No**
How long did the bleeding last?
_____
How did you stop the bleeding?
_____

- Do you have any ulcerations, sores, or non-healing wounds? **Yes** **No**

If yes, which leg and location on leg?
_____

- Do you experience swelling in your legs? **Yes** **No**

If yes, does one leg swell worse than the other and which leg?
_____
When is the swelling worse?
_____
How long does swelling last?
_____

- Have any of the following conservative therapies been used:

Compression socks or hose (medical grade 20/30mm or greater) ? **Yes** **No**
If yes, how long have you been wearing compression socks or hose?
_____
How often do you wear them? _____ While wearing, do you experience relief? **Yes** **No**
While wearing, do you have discomfort? **Yes** **No** While wearing do you experience itching? **Yes** **No**
When you remove them, is there discomfort? **Yes** **No**
Do you elevate your legs? **Yes** **No** If yes, how long? _____ How often? _____
Weight Loss?
_____
Additional Information or therapies:
_____

- Do your symptoms interfere with any of the following: Daily activities? **Yes** **No** Work? **Yes** **No**

Exercising? **Yes** **No** Sleeping? **Yes** **No** Other Activities:
_____

- Do your legs cramp during the day? **Yes** **No** Cramping at Night? **Yes** **No**
- Have you taken any over-the-counter medications? **Yes** **No**

If so, what medications and did it help relieve any symptoms?
_____
_____
_____

- Have you experience any change in normal activity/lifestyle due to moderate/severe pain? **Yes** **No**
- Work Duties:
  _____
  _____

Are you required to: Stand for long periods? **Yes** **No** Heavy Lifting? **Yes** **No**
Climbing stairs/ladders? **Yes** **No**

- Please list any additional information:
  _____

_____
_____
_____
_____