VARICOSE VEIN QUESTIONNAIRE

Name: _____ **DOB**: ____/____/_____ **Age**: ____ **Sex**: _____

Height: _____ **Weight**: _____

1. How many years have you noticed this problem? _____

2. Have you ever been previously treated for this problem? _____

   By whom and when? _____

   With what method?

Stockings/conservative	___	___
Injection	___	___
Laser	___	___
Surgery	___	___

3. When did your veins occur?

Age	___	___
Before pregnancy	___	___
After pregnancy	___	___
After trauma	___	___
After birth control	___	___

   Other: _____

4. Which leg? ____ Right leg ____ Left leg ____ Both legs

5. Is there a family history of varicose or spider veins?

Mother	___	___
Father	___	___
Sister	___	___
Brother	___	___
Children	___	___
Aunts	___	___
Uncles	___	___

6. Current medications (list all, including over-the-counter): _____

   _____

   _____

   _____

7. Allergies: _____

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	YES	NO
8. Do you have a history of:		
Asthma or wheezing	___	___
Migraine	___	___
Thrombophlebitis	___	___
Pulmonary embolus	___	___
Deep vein thrombosis [DVT]	___	___
Lupus	___	___
Hepatitis	___	___
Bleeding disorders	___	___
Easy bruisability	___	___
Born or acquired heart condition	___	___
Swollen feet/ankles	___	___
Leg injury or surgery	___	___
Other	___	___
9. Are you developing new veins?	___	___
10. Are your present veins getting bigger?	___	___
11. Does walking or exercise relieve or aggravate the pain?	___	___
12. Are you required to be on your feet for long periods?	___	___
13. Do you jog, run, jump rope, or do aerobics?	___	___
14. Are you pregnant or planning a pregnancy soon?	___	___
15. Do you smoke cigarettes?	___	___
16. Do you have leg eczema or dermatitis?	___	___
17. Did you have leg cellulitis?	___	___
18. Is the skin on your legs dry and itchy?	___	___
19. Do you feel leg tiredness and heaviness?	___	___
20. Do you feel leg throbbing and burning pain?	___	___
21. Did you notice change in your lower leg skin color and hardness?	___	___
22. Do you have ankle and/or leg swelling?	___	___
23. Do you take pain medications for your leg pain?	___	___

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24. Are your symptoms worse with:

    ____ Sitting ____ Standing ____ Working ____ End of day ____ Menstruation

    ____ Other: _____

25. Are your symptoms improved with:

    ____ Elevation ____ Compression ____ Rest ____ Pain medications

    ____ Other: _____

26. How many pregnancies have you had? How many children do you have?

    _____

    _____

27. What is your occupation? _____

    How long have you been working? _____

28. If retired, indicate time of retirement. What was your occupation?

    _____

29. Did/does your job require you prolonged walking and standing? If yes, how many hours estimated?

    _____

Today's date: _____