Initial and Follow-up Questionnaire

Name: _____ Date: _____

MR #: _____ DOB: _____

Occupation: _____

Visit: ☐Initial ☐3months ☐6months ☐_____Years ☐Other: _____

Blood pressure:_____ Normal: Systolic less than or equal to 120 and diastolic less than or equal to 80.

Lifestyle modifications recommended _____ and referral to PCP_____

Please answer the following questions

Have you ever used any tobacco products (Cigarettes, Chewing Tobacco, Cigars)? No ☐ Yes ☐

If yes, how often?_____ Quit, how long ago?_____

Are you older than 65? No ☐ Yes ☐ If yes, do you have an advanced care plan or surrogate decision maker? No ☐ Yes ☐

If yes, please let us know your plan and decision maker. _____
Or ☐ I prefer not to discuss my plan.

How many times in the past year have you had 5 (for men) or 4 (for women and adults greater than 65 years old) or more drinks in a day? **Please check box that applies** 0 ☐ 1 ☐ 2 ☐ More than 2 times ☐

Current Medications: Please list on back if necessary

Medication Name	Dose	How often	Route by mouth (PO) or other
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies (please list):

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Symptoms: (Please check if yes)	**R**	**L**
Aches/pains in legs	☐	☐
Heaviness	☐	☐
Tiredness/fatigue	☐	☐
Itching/burning	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Do your symptoms interfere with walking? ☐
Do your symptoms worsen with or after activity? ☐

Check if you've had any of the following

Heart disease	☐
Contagious Disease	☐
Hepatitis	☐
High blood pressure	☐
Diabetes	☐
Cancer	☐
Leg Trauma/Surgery	☐
Major Surgeries/Hospitalizations	☐

(Please list on back if necessary)

_____

_____

Conservative Measures Used Currently or Previously: (Please check those measures that you have tried)

Pain medications or herbal supplements ☐ Leg Elevation ☐ Exercise ☐ Job Change ☐
Compression stockings or leg wraps ☐ If so, how long?_____ Weight Loss ☐

Please check box if you have, or have had any of the following:

Prior evaluation for your veins?	☐	Family history of vein disease?	☐
Previous vein surgery or laser treatment?	☐	Family history of leg ulceration?	☐
Previous vein injections?	☐	Family history of blood clots?	☐
Bleeding from a vein?	☐		
Leg ulceration?	☐		
Phlebitis?	☐		
Any type of blood clot/clotting disorder?	☐		
(If so, were you treated with blood thinners?)	☐		

Follow up questionnaire counseling (Staff use only)

Tobacco cessation given: yes ☐ not needed ☐
Surrogate or Advanced Care counseling given: yes ☐ not needed ☐ patient refused ☐
Alcohol abuse counseling given: yes ☐ not needed ☐

Physician: _____ Date: _____