Varicose Vein Office Examination Questionnaire

Patient Last Name_____ Patient First Name_____ Date____/____/____

Date of Birth: ____/____/____ Age: _____ Sex: M / F E-mail: _____

Primary Physician: _____ Referring Physician: _____

Have you ever been hospitalized before? Yes No

If yes, please specify when and for what reason: _____

Are you in a skilled nursing facility? Yes No If yes, please name facility:_____

Have you ever had surgery of any kind? Yes No

If yes, please explain: _____

_____

Please list any allergies you may have: _____

Please list all of the medications that you currently take (please include doses and how often) _____

_____

Vein History

What is the reason why you are seeking treatment? Cosmetic Medical

Have you seen any other doctors for treatment of your veins? Yes No

If yes, please explain: _____

Do you or have you ever worn compression stockings? Yes No

If yes, please list what type you use(d): _____ Do/did they help? Yes No

Have you ever had a blood clot in your legs? Yes No

If yes, please detail when and in which leg: _____

Do you experience any of the following symptoms in your legs?

Aching/Pain	Yes	No	Swollen Ankles	Yes	No
Heaviness	Yes	No	Leg Cramps	Yes	No
Tiredness/Fatigue	Yes	No	Throbbing	Yes	No
Itching/Burning	Yes	No	Restless Legs	Yes	No
Skin Changes	Yes	No			

Please list any other leg symptoms: _____

Do you have problems walking? Yes No

If yes, please explain: _____

Are your symptoms worse at the end of the day? Yes No

Are the problems you are having in your legs interfering with your lifestyle? Yes No