Varicose Veins Questionnaire

Patient Name: ________________________________ Sex: __________

Date of Birth: __________ Primary Care Doctor: ________________________

Why are you here today? ________________________________

How did you hear about us? ________________________________

Have you ever or do you currently have a work-related injury having to do with your condition? Yes / No

Do you have a cardiologist? Yes / No Doctor: ______________________

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

(please specify right, left or both legs)

____ varicose veins	____ discoloration
____ ulcers/non-healing wounds	____ burning
____ aching/pain	____ swollen ankles
____ heaviness	____ leg cramps
____ tiredness/fatigue	____ restless legs
____ itching	____ throbbing

Have you ever seen a physician for varicose veins? Yes / No

Doctor: ______________________ Date ______________

Do you wear compression stockings? Yes / No

If yes, for how long? ______________________

Have you ever had vein surgery, stripping or injections? Yes / No

If yes, when and which leg? ________________________________

Have you ever had blood clot? Yes / No

If yes, when and which leg? ________________________________

Have you ever had phlebitis? Yes / No

If yes, when and which leg? ________________________________

Have your symptoms gotten worse in the past few months? Yes / No

Do you elevate your legs to relieve discomfort? Yes / No

Cardiovascular History

Please check any item that applies to you. Please provide date and where it occurred:

____ Heart Attack	____ Cardiac Angiogram or Cath
____ Heart Surgery (Bypass or Valvular)	____ Cardiac Angioplasty / Stent
____ Congestive Heart Failure	____ Peripheral Angiogram
____ Ultrasound of your legs	____ Peripheral Artery Stent
____ Peripheral Artery Bypass	

Have you ever had problems with anesthesia? If yes, please explain:

____

Allergies (please list medication and reaction)

____

____

____

Medication History

Please list all medications, Prescriptions, Aspirin products, Over the Counter, Vitamins and Nutritional Supplements

Name of Drug	Dose (mg)	How often you take medication

Are you taking Coumadin (warfarin)? If so, which doctor follows your Coumadin Therapy:

Yes / No ______________________________

Are you or have you been treated for any medical problems?

____ Hypertension
____ Hypercholesterolemia
____ Renal Disease
____ Diabetes
____ Cancer
____ Stroke
____ TIA
____ Mental Health Illness
____ Depression
____ Anxiety Disorder
____ Deep Vein Thrombosis
____ Pulmonary Embolism
____ Atrial Fibrillation
____ Cellulitis
____ Lymphedema

Surgical History

List any surgeries that you have had:

____

____

____

____

Social History & Habits

This will remain strictly confidential, please be honest in your responses. We realize these may be sensitive issues, but they are very important to know in treating your cardiovascular health

_____ Tobacco: Currently smoking? Yes / No Never smoked Chew? Yes / No

When did you quit? _______________ packs per day __________ for how long _______________

_____ Alcohol: How much and how often? _________________________

_____ Caffiene: Type(s) ____________________ How much per day ? ____________________

_____ Recreational Drugs (Current/past) What substance and last use? ______________________________

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father Yes / No Mother Yes / No

Brother(s) Yes / No Sister(s) Yes / No

Occupation: ___________________________________ Employer: ____________________________

Do you exercise? Yes / No If yes, what type? ____________________________

How many days per week? _______________ How many minutes per day? _______________

Do your symptoms get worse with exercise? Yes / No

Symptom Review

Check any of the following symptoms you have experienced in the past month:

_____ Fatigue
_____ Fever
_____ Headaches
_____ Loss of appetite
_____ Weakness
_____ Weight gain
_____ Weight loss
_____ Cold
_____ Cough (productive / dry)
_____ Nose bleeds
_____ Hearing loss
_____ Ringing in the ears
_____ Sore throat
_____ Acid reflux
_____ Abdominal Pain
_____ Blood in stool
_____ Constipation
_____ Diarrhea
_____ Difficulty swallowing
_____ Heartburn
_____ Nausea
_____ Vomiting
_____ Bleeding
_____ Easy bruising
_____ Fatigue

_____ Carpal Tunnel
_____ Fracture (bone)
_____ Joint pain
_____ Joint stiffness
_____ Joint swelling
_____ Leg cramps
_____ Muscle aches
_____ Dizziness
_____ Gait abnormality
_____ Insomnia
_____ Memory loss
_____ Seizures
_____ Tingling/numbness
_____ Blurry vision
_____ Diminished vision
_____ Eye irritation
_____ Loss of vision
_____ Seasonal eye symptoms
_____ Blood in urine
_____ Difficulty urinating
_____ Frequent urination
_____ Urination at night
How many times per night?
_____ Urinary incontinence
_____ Voiding dysfunction