



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:

---

---

---

---

---

**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?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> TIA                   | <input type="checkbox"/> Pulmonary Embolism   |
| <input type="checkbox"/> Renal Disease        | <input type="checkbox"/> Mental Health Illness | <input type="checkbox"/> Atrial Fibrillation  |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Depression            | <input type="checkbox"/> Cellulitis           |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Anxiety Disorder      | <input type="checkbox"/> 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? \_\_\_\_\_  
 \_\_\_\_\_ Caffeine: 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                  | _____ Carpal Tunnel             |
| _____ Fever                    | _____ Fracture (bone)           |
| _____ Headaches                | _____ Joint pain                |
| _____ Loss of appetite         | _____ Joint stiffness           |
| _____ Weakness                 | _____ Joint swelling            |
| _____ Weight gain              | _____ Leg cramps                |
| _____ Weight loss              | _____ Muscle aches              |
| _____ Cold                     | _____ Dizziness                 |
| _____ Cough (productive / dry) | _____ Gait abnormality          |
| _____ Nose bleeds              | _____ Insomnia                  |
| _____ Hearing loss             | _____ Memory loss               |
| _____ Ringing in the ears      | _____ Seizures                  |
| _____ Sore throat              | _____ Tingling/numbness         |
| _____ Acid reflux              | _____ Blurry vision             |
| _____ Abdominal Pain           | _____ Diminished vision         |
| _____ Blood in stool           | _____ Eye irritation            |
| _____ Constipation             | _____ Loss of vision            |
| _____ Diarrhea                 | _____ Seasonal eye symptoms     |
| _____ Difficulty swallowing    | _____ Blood in urine            |
| _____ Heartburn                | _____ Difficulty urinating      |
| _____ Nausea                   | _____ Frequent urination        |
| _____ Vomiting                 | _____ Urination at night        |
| _____ Bleeding                 | _____ How many times per night? |
| _____ Easy bruising            | _____ Urinary incontinence      |
| _____ Fatigue                  | _____ Voiding dysfunction       |