

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_

Please check leg symptoms you currently have or have experienced in the past 3 months:

	Right	Left
<i>no symptoms</i>	<input type="checkbox"/>	<input type="checkbox"/>
aching	<input type="checkbox"/>	<input type="checkbox"/>
restlessness	<input type="checkbox"/>	<input type="checkbox"/>
heaviness	<input type="checkbox"/>	<input type="checkbox"/>
itching	<input type="checkbox"/>	<input type="checkbox"/>
burning	<input type="checkbox"/>	<input type="checkbox"/>
cramping	<input type="checkbox"/>	<input type="checkbox"/>
throbbing	<input type="checkbox"/>	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	<input type="checkbox"/>
swelling	<input type="checkbox"/>	<input type="checkbox"/>
other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Do your symptoms interfere with sleep? -Yes -No

Do they interfere with walking? -Yes -No

On a scale of 1-10, with 1 being *slightly bothersome* and 10 being, *severely affecting my life*, I consider my vein disease to be:

1   2   3   4   5   6   7   8   9   10

Are your varicose or spider veins located in another area besides your leg? If so, where?

\_\_\_\_\_

\_\_\_\_\_

**Please check if you have ever had:**

	Right	Left
<input type="checkbox"/> leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> bleeding from a vein	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> blood clot/phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> vein surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> prior vein evaluation/treatment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> vein injections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> leg injury/trauma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> heart disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> migraine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> high blood pressure		
<input type="checkbox"/> HIV ( <i>AIDS</i> )		
<input type="checkbox"/> diabetes		

Do you have a family history of?

heart disease    leg ulcers    diabetes  
 varicose veins    clotting disorders

Do you smoke? \_\_\_\_\_. Packs per day \_\_\_\_

Do you drink alcohol? \_\_\_\_\_

OTC Medications/Prescription      Allergies


(Please list on back, if more space is needed)

**Please check Yes or No:**

I have tried elevation of my legs to relieve discomfort for \_\_\_\_\_ months.    -Yes -No

I have tried elastic support/compression stockings.    -Yes -No

If Yes: What type?    How long?

\_\_\_\_\_

I have taken medication for my leg symptoms.    -Yes -No

If Yes: What medication?    How long?

\_\_\_\_\_

Standing makes my symptoms worse. -Yes -No

I stand \_\_\_\_\_ hrs. per day.

Please list any surgeries/hospitalizations (*other than vein surgeries*) and month/year:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your occupation:

\_\_\_\_\_

**For Women only:**

Are you pregnant or considering pregnancy in the near future?    -Yes -No

Are you breastfeeding?    -Yes -No

Worsening of symptoms during pregnancy?    -Yes -No

Worsening of symptoms around menstrual cycle?    -Yes -No

Number of pregnancies? \_\_\_\_\_. Deliveries? \_\_\_\_\_

Do you use birth control pills or take estrogen replacement therapy?    -Yes -No

**Signature:**

\_\_\_\_\_