VARICOSE VEIN QUESTIONNAIRE

PATIENT NAME:_____
DATE OF BIRTH:_____
TODAY'S DATE:_____

1.) How long have you had varicose veins? _____

2.) ___Right ___Left

3.) Do you suffer from:

___Bleeding ___Burning ___Discoloration ___Fatigue ___Heaviness __Itching

___ Pain ___Phlebitis ___Skin Changes ___Soreness ___Ulcers

4.) Do your symptoms interfere with long activities such as:

___exercise ___sitting ___standing ___walking

Other_____

Conservative Treatment: For relief of symptoms are you:

__Walking __ Leg elevation __OTC pain relievers __ Weight loss

__ Prescription Grade Compression Hose __ Knee High __Thigh High

_____ When did you start wearing compression hose

Y or N Do you wear them daily?

Please list any other treatment you have received for your varicose veins.

_____
_____
_____
_____
_____

For Women:
Are you pregnant or nursing? _____
Are your symptoms worse during your menstrual cycle?_____