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VARICOSE VEINS QUESTIONNAIRE

PATIENT NAME _____ DATE _____

1. What problems are you having with your veins? _____

_____

_____

2. How long have you been having this/these problems? _____

_____

3. Does anyone in your family have problems with their veins? ☐ Yes ☐ No If Yes, who? _____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

4. Phlebitis or clots? ☐ Yes ☐ No If Yes, ☐ Right Leg ☐ Left Leg Were you hospitalized? ☐ Yes ☐ No

5. Blood clot(s) to lungs or heart? ☐ Yes ☐ No If Yes, When? _____

6. Ulcer or sore near ankle? ☐ Yes ☐ No If Yes, How many times? _____
   Please give the following information per each instance and use back of page if needed.

   Date _____ R ☐ L ☐ Date _____ R ☐ L ☐
   Date _____ R ☐ L ☐ Date _____ R ☐ L ☐
   Date _____ R ☐ L ☐ Date _____ R ☐ L ☐

7. Veins surgically removed? ☐ Yes ☐ No If Yes, ☐ R When? _____ ☐ L When? _____
8. Veins injected? ☐ Yes ☐ No If Yes, ☐ R When? _____ ☐ L When? _____
   Did you wear compression stockings after injections? ☐ Yes ☐ No
9. Injuries to your legs? ☐ Yes ☐ No If Yes, ☐ R When? _____ ☐ L When? _____
10. Have you ever worn compression stockings? ☐ Yes ☐ No If Yes, please provide the following:
    Were they medical grade (prescribed by a doctor)? ☐ Yes ☐ No Strength of compression? _____
    Were you measured for your stockings by a professionally trained individual? ☐ Yes ☐ No
    Were they: Below-the-knee ☐ Thigh-high ☐ Support pantyhose/Waist-high leotards ☐
11. Do you have a history of back problems? ☐ Yes ☐ No If Yes, did it involve your leg(s)? ☐ R ☐ L
12. Do you have a problem with your: Back ☐ Heart ☐ Arms ☐ Hands ☐ that would prevent you from pulling on support stockings? What is your Height? _____Ft _____In Weight? _____ If you checked any, please describe:

    _____

    If you have had past problems, have you tried a stocking donner? ☐ Yes ☐ No

13. Do you elevate your legs? ☐ Yes ☐ No If Yes, please provide the following:

    How many times a day? _____ How long each time? _____ How high? _____

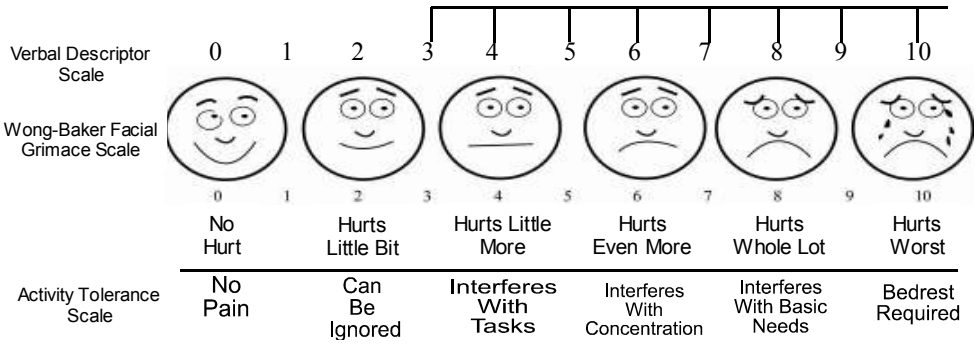
    Do you have a medical reason that prevents you from elevating your legs? ☐ Yes ☐ No If Yes, describe:

    _____

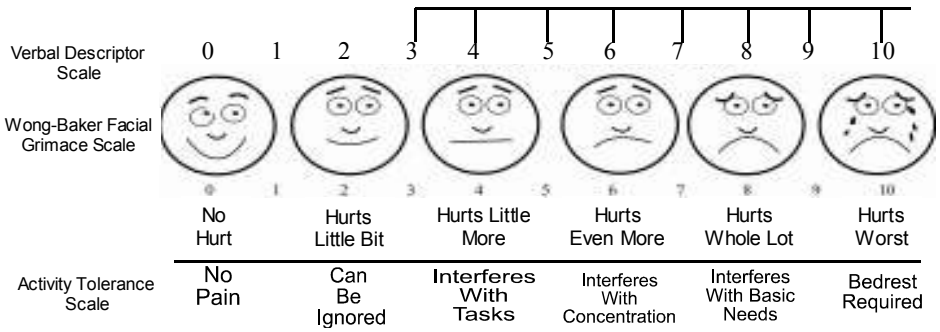
14. What makes your pain worse? _____

15. What makes your pain better? _____

16. On <u>average</u>, how bad is your pain and please describe using the following scale:



17. During a full day, how bad is your pain at its worst and please describe using the following scale:



18. Do you have other concerns about your legs or veins that you would like to discuss with Dr. Brazil?_____

    _____

    _____

    _____

    _____

    _____

    (Please use the back of the page if additional space is needed for any of the above questions.)