Florida Vascular Specialists
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VARICOSE VEIN QUESTIONNAIRE

PATIENT'S NAME: _____

DOB: _____ **AGE:** _____ **GENDER:** _____

1. **Do you experience any of the following sensations in your legs? Please choose all that apply.**

☐ Aching ☐ Heaviness ☐ Fatigue ☐ Burning ☐ Cramping ☐ Throbbing
☐ Pain ☐ Tiredness ☐ Itching ☐ Swelling ☐ Restless legs ☐ Other: _____

2. **When did you first notice Vein-Related discomfort?** _____

3. **How does your leg pain affect your daily activities?** _____

4. **Have your veins worsened in recent months?** ☐ YES ☐ NO

5. **Does elevating your legs relieve your discomfort?** ☐ YES ☐ NO

6. **Do you wear support/compression hose prescribed by a doctor?** ☐ YES ☐ NO

- If YES, for how long? _____
  - Do they provide relief? ☐ YES ☐ NO

7. **Have you ever had bleeding with your leg veins?** ☐ YES ☐ NO

8. **Do you have any problem walking?** ☐ YES ☐ NO

9. **Have you ever had any tests done on your veins?** ☐ YES ☐ NO

10. **Have you ever had your veins evaluated?** ☐ YES ☐ NO

- If so, when, and where? _____

11. **Have you ever had vein stripping or phlebectomy surgery?** ☐ YES ☐ NO

- If so, When, Where, and Which leg? _____

12. **Have you ever had sclerotherapy vein injection?** ☐ YES ☐ NO

- If so, When, Where, and Which leg? _____

13. **Have you ever had a blood clot?** ☐ YES ☐ NO

14. **Have you ever had phlebitis?** ☐ YES ☐ NO

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- If YES, When and which leg? _____

15. **Have you had a venous stasis ulcer?** ☐ YES ☐ NO

16. **Does anyone in your family have varicose veins, spider veins, or leg ulcers? Please choose all that apply.**

☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Children

How did you hear about us?

☐ Website ☐ Physician ☐ Radio ☐ Insurance List

☐ TV ☐ Event ☐ Friend ☐ Other: _____

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