

VARICOSE VEIN/SPIDER VEIN QUESTIONNAIRE

Name: _____

Please circle all that apply:

Date: _____

1. Which of the following do you have:

- | | |
|--|---|
| Varicose veins (bulging, twisted, rope-like veins) | Spider veins (fine veins on skin surface) |
| Both varicose and spider veins | Don't know |

2. Please circle if you are allergic to: Topical Iodine Local anesthetic (xylocaine) Tape (if so, is paper tape okay?)

3. Do you have a family history of varicose veins? Yes No Who: _____

4. Do you have a family history of blood clots? Yes No Who: _____
Did he/she have the blood clot after major surgery? Yes No If no, what circumstances was it under: _____

5. How many years have you had varicose or spider veins? _____

6. What is your occupation? _____

7. Please circle any previous vein treatment:

compressive stockings: pantyhose, thigh highs, or knee highs
Prescriptive or Over-the-counter
How often & since when: _____

sclerotherapy (injection): saline / other medication

vein stripping: which leg: Right Left when: _____

incision at groin: Yes No Don't know

other incision location: _____

local varicose vein removal/excision

laser (where, with whom) _____

- | | | | |
|-------------------------------------|------------------------------|-------|------|
| 8. Do you now have or have you had: | Unightly veins | Right | Left |
| | Aches and pains in legs | Right | Left |
| | Heaviness or tired legs | Right | Left |
| | Ankle swelling | Right | Left |
| | Itching in legs | Right | Left |
| | Night cramps | Right | Left |
| | Bleeding from the veins | Right | Left |
| | Pigmentation (discoloration) | Right | Left |
| | Dermatitis (eczema) | Right | Left |
| | Ulceration in legs | Right | Left |
| | Which leg hurts more? | Right | Left |

9. What activities cause your leg pain and what brings relief?

10. Most insurance require documentation of analgesic when considering coverage for varicose vein treatment. Please list any medication you have even taken for leg ache including prescriptive and over-the-counter medicine (Example: Tylenol, Motrin, Aleve, ibuprofen, & others) _____

11. I exercise (please circle): daily regularly 2-3 times per week seldomly

- | | | | | | |
|---|--|-----|----|-------|------|
| 12. Do you currently <u>have or had</u> history of: | Blood Clots (that required blood thinner) | Yes | No | Right | Left |
| | Superficial phlebitis (clots in surface veins) | Yes | No | Right | Left |
| | Pulmonary emboli (blood clots in lung) | Yes | No | Right | Left |
| | Diabetes | Yes | No | | |
| | Congestive Heart Failure (CHF) | Yes | No | | |
| | Vascular surgery | Yes | No | | |
| | Heart or bypass surgery | Yes | No | | |
| | Recent leg trauma | Yes | No | | |