

# Varicose Vein Office Examination Questionnaire



## Vein History - Please circle Yes or No

What is the reason why you are seeking treatment? Please explain: \_\_\_\_\_

Have you seen any other doctors for treatment of your veins? YES NO  
If yes, please explain: \_\_\_\_\_

Do you or have you ever worn compression stockings? YES NO  
Do/did they help? YES NO

Have you ever had a blood clot in your legs? YES NO  
If yes, please detail when and in which leg: \_\_\_\_\_

Do you experience any of the following symptoms in your legs?

Aching/Pain	YES	NO	Swollen Ankles	YES	NO
Heaviness	YES	NO	Leg Cramps	YES	NO
Tiredness/Fatigue	YES	NO	Throbbing	YES	NO
Itching/Burning	YES	NO	Restless Legs	YES	NO

Do you have problems walking? YES NO  
If yes, please explain: \_\_\_\_\_

Are your symptoms worse at the end of the day? YES NO

Are the problems you are having in your legs interfering with your lifestyle? YES NO



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