Fayetteville Vascular and Vein Center, P. A.

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American Board of Surgery Certified
General, Vascular and Endovascular Surgery

Vein Questionnaire

Confirmed Symptoms

Aching/Pain in Legs	❑ Right	❑ Left	❑ Bilateral	❑ None
Heaviness	❑ Right	❑ Left	❑ Bilateral	❑ None
Tiredness/Fatigue	❑ Right	❑ Left	❑ Bilateral	❑ None
Leg Cramping	❑ Right	❑ Left	❑ Bilateral	❑ None
Leg Restlessness	❑ Right	❑ Left	❑ Bilateral	❑ None
Throbbing	❑ Right	❑ Left	❑ Bilateral	❑ None
Swelling	❑ Right	❑ Left	❑ Bilateral	❑ None
Leg Venous Ulcer	❑ Right	❑ Left	❑ Bilateral	❑ None

Do symptoms interfere with sleep.	❑ Yes	❑ No	❑ N/A
Do symptoms interfere with walking.	❑ Yes	❑ No	❑ N/A

On a scale of 'slightly bothersome' (1) to 'severely affecting my life' (10)
Vein disease is described as ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Pain improved with

Pain medications or herbal supplements	❑ Yes	❑ No	❑ Never tried
Leg elevation	❑ Yes	❑ No	❑ Never tried
Exercise	❑ Yes	❑ No	❑ Never tried
Job change	❑ Yes	❑ No	❑ Never tried
Weight loss	❑ Yes	❑ No	❑ Never tried
Compression stockings or leg wraps	❑ Yes	❑ No	❑ Never tried

Used for ______ months ________years

Prescribed by ❑ Self ❑ Primary Care Physician ❑ Vascular Surgeon

Strength ❑ 15-20mmhg ❑ 20-30mmhg ❑ 30-40mmhg

Medical History

Heart Disease	❑ Yes	❑ No
Contagious Disease	❑ Yes	❑ No
Hepatitis/HIV	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No

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Cancer	❑ Yes	❑ No	
Leg Trauma/Surgery	❑ Yes	❑ No	
Other Surgeries/Hospitalizations	❑ Yes	❑ No	Describe: ________________________________

Vascular History

Prior Evaluation of Veins	❑ Yes	❑ No	Date: __________________________
Previous Vein Surgery	❑ Yes	❑ No	Date: __________________________
Previous Vein Injections	❑ Yes	❑ No	Date: __________________________
A Leg Ulceration	❑ Yes	❑ No	
Phlebitis	❑ Yes	❑ No	
Clotting Disorder	❑ Yes	❑ No	
Treated with Blood Thinners	❑ Yes	❑ No	

Family Vascular History

Leg Ulceration	❑ None	❑ Mother	❑ Father	❑Grandparent	❑Sibling	❑Son	❑Daughter.
Blood clots	❑ None	❑ Mother	❑ Father	❑Grandparent	❑Sibling	❑Son	❑Daughter.
Varicose Veins	❑ None	❑ Mother	❑ Father	❑Grandparent	❑Sibling	❑Son	❑Daughter.

Restless Leg Syndrome

Need to move legs to relief an uncomfortable feeling	❑ Yes	❑ No	❑ N/A
Legs feel better when moving them or walking	❑ Yes	❑ No	❑ N/A
Legs feel worse when sitting or resting without elevating them	❑ Yes	❑ No	❑ N/A
Symptoms are worse later in the day or night	❑ Yes	❑ No	❑ N/A

Women Only

You are pregnant or considering pregnancy	❑ Yes	❑ No
You are breastfeeding	❑ Yes	❑ No
Your legs are more painful when menstruating	❑ Yes	❑ No
You have been diagnosed with pelvic congestion syndrome	❑ Yes	❑ No

Number of pregnancies: _______ Number of deliveries: ___________ Ages of children: ___________________

I understand that photographs may be taken during my office visit for documentation purpose only.

Patient signature: _______________________________________ Date: ___________________________________

Physician Signature: _____________________________________ Date: ____________________________________

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