**Via Christi Plastic Surgery & Aesthetics**
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# Vein Questionnaire

Patient Name: _____ Date of Birth: _____
Referring Physician: _____ Age: _____

**Please answer the following questions:**

**Do you experience any of the following in your legs?** *(Circle all that are applicable)*

| | | | | | |
|---|---|---|---|---|---|
| Aching/pain? | Yes | No | Right leg | Left leg | Both Legs |
| Heaviness? | Yes | No | Right leg | Left leg | Both Legs |
| Tiredness/fatigue? | Yes | No | Right leg | Left leg | Both Legs |
| Itching/burning? | Yes | No | Right leg | Left leg | Both Legs |
| Swollen ankles? | Yes | No | Right leg | Left leg | Both Legs |
| Leg cramps? | Yes | No | Right leg | Left leg | Both Legs |
| Restless legs? | Yes | No | Right leg | Left leg | Both Legs |
| Throbbing? | Yes | No | Right leg | Left leg | Both Legs |

How long have you had these symptoms? _____
_____

Have your veins gotten worse in recent months? Yes No
_____

Does prolonged sitting/standing make your leg pain worse? Yes No

Does lying flat, leg elevation, or walking make your leg pain better? Yes No

Do you take Birth control medication? _____

Number of pregnancies: _____ Number of live births: _____

Are you on any hormone replacement therapy? _____

Have you worn compression stockings? Yes No

If yes, what type? (Over the Counter or Prescription) _____

Do you take any medication for leg pain? (i.e., Advil, Motrin, or Lortab) Yes No

Are you employed or retired? _____
If employed, what type of work do you do? _____
What percentage of the day do you spend sitting or standing? _____

## Past Medical History

Have you ever had vein stripping surgery? Yes No
If yes; which leg and when? _____

Have you ever had leg vein injections? Yes No
If yes; which leg and when? _____

Have you ever had a blood clot or phlebitis in your legs? Yes No
If yes; which leg and when? _____

Is there any family history of blood clots or phlebitis? Yes No
If yes; who and when? _____

Have you ever had a leg fracture or joint surgery? Yes No
If yes; which leg and when? _____

## Family History

**Does anyone in your family have a history of varicose veins?**

Father Yes No Treatment: _____

Mother Yes No Treatment: _____

Brother(s) Yes No Treatment: _____

Sister(s) Yes No Treatment: _____

Other Yes No Treatment: _____

## Review of Systems

**Are you currently experiencing any of the following?** *(Please circle)*

Fever Chills Shortness of Breath Cough Wheezing

Chest Pain Heart Palpitations Nausea Vomiting Diarrhea