

Raleigh Surgical Group

Vein Evaluation Questionnaire

Patient Name _____ Age _____ Birthday _____ Visit Date _____
 Referring Doctor _____
 Primary Care Physician _____ Surgeon (who you are seeing today) _____

Vein symptoms: Please check all that apply.

	Left leg	Right leg
Aching	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness/fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Itching/burning	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>
Bulging veins	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	<input type="checkbox"/>	<input type="checkbox"/>

Pain symptoms: For leg pain, please describe:

Location: _____
 Timing: (continuous, occasional, episodic) _____
 Duration (min/hrs, AM/PM) _____
 Quality (ache, sharp, dull, burning, tired, cramp, numb, etc) _____
 Severity (1-10) _____
 What makes it better/worse (heat, cold, rest, walking, elevation, etc) _____

Vein History

- When did you first notice the above symptoms? _____
- Have your symptoms gotten worse recently? _____ Yes _____ No
- Do you elevate your legs to relieve discomfort? _____ Yes _____ No
- Do you/have you used any type of support/compression hose? _____ Yes _____ No
 - If so, are/were they prescription hose? _____ Yes _____ No
 - How long have you worn them? _____ Dates: _____
 - Strength (level) of compression? _____ mmHg
 - Do they provide relief? _____ Yes _____ No
- Do you take pain medicine for your legs? _____ Yes _____ No
 - Which medication? _____
 - What dose? _____
 - For how long? _____
 - Dates of therapy: _____
- Do you exercise (including walking) regularly? _____ Yes _____ No
- Have you lost weight in an attempt to relieve your symptoms? _____ Yes _____ No
- Have you ever had a leg ulcer due to vein disease? _____ Yes _____ No
 - If so, did it heal? _____ Yes _____ No
 - If so, did it recur? _____ Yes _____ No
- Have you had recurrent superficial thrombophlebitis? _____ Yes _____ No
- Have you ever had a deep vein thrombosis (blood clot)? _____ Yes _____ No
- Have you ever had bleeding from a varicose vein? _____ Yes _____ No
 - If so, multiple times? _____ Yes _____ No
 - Ever need a transfusion due to bleeding veins? _____ Yes _____ No
- Have you ever had your veins evaluated before? _____ Yes _____ No
 - If so, where and when? _____
- List at least **two** specific activities with which your symptoms interfere, including occupational duties if applicable (shopping, showering, playing with children, walking, standing at work, etc):
 - _____ How does it interfere? _____
 - _____ How does it interfere? _____

Physician to complete:

Standing Photo _____ >=2+ edema documented _____ Rx hose _____
 Duplex ordered _____ Referring MD records (for class 0-4) _____ F/U appt _____
 Vein class (0-6) _____ Insurance _____