



PATIENT HISTORY & VEIN HEALTH QUESTIONNAIRE

Patient name: _____ Today's date: _____

☐ Female ☐ Male

Date of birth: ____ / ____ / ____

Primary care physician: _____

Occupation: _____

1. HISTORY OF PRESENT ILLNESS/VEIN HISTORY

Current symptoms you are experiencing

Check every symptom that applies and identify the affected leg(s).

Which leg(s) do you experience symptoms: Right ____ Left ____ Both ____

SYMPTOMS:

Persistent Pain/Aching ____ Heaviness ____ Tiredness/Fatigue ____ Bulging/Visible veins ____

Itching (☐ above knee ☐ below knee) ____ Burning/Hot sensation ____ Swelling/Edema ____

Restlessness ____ Cramping/Soreness ____ Throbbing/Tingling ____ Numbness ____

When did you first notice these vein related symptoms (estimated time frame is ok):

When are symptoms most noticeable (check all that apply):

☐ Morning ☐ Daytime ☐ Evening ☐ Night ☐ After standing/sitting

Skin changes and Appearance

Please choose one answer for each question unless the question asks about each leg separately.

Question	Response
1. How many days of the week do the varicose veins cause pain/aching or lower leg/ankle swelling:	☐ 1-3 days ☐ 3-5 days ☐ 5-7 days
2. How many days of the week do the varicose veins wake you from your sleep or prevent you from falling asleep:	☐ 1-3 days ☐ 3-5 days ☐ 5-7 days
3. Skin discoloration of lower leg/ankle and/or feet:	☐ Yes ☐ No
4. Rash or eczema around lower leg/ankle:	☐ Yes ☐ No
5. Have you ever or do you currently have a skin sore/open wound/ulcer that will not/has not healed:	☐ Right ☐ Left ☐ Both ☐ No How long: _____

Patient Signature _____ Date _____

Symptom severity and effect on daily activities

Circle one number: 1 = not bothered/not painful and 5 = bothered all the time/very painful.

Activity or symptom	Rating
Overall ankle or leg pain/discomfort	1 2 3 4 5
Work or usual daily duties (housework, cooking, yard work)	1 2 3 4 5
Falling asleep or staying asleep	1 2 3 4 5
Standing for a long time	1 2 3 4 5
Climbing stairs, crouching, or kneeling	1 2 3 4 5
Brisk or long-distance walking	1 2 3 4 5
Traveling by car, bus, train, or plane	1 2 3 4 5
Social/leisure activities (parties, weddings, dancing)	1 2 3 4 5
Strenuous exercise or sports	1 2 3 4 5
Swelling of the feet or legs	1 2 3 4 5

If any were answered 3 through 5, describe how symptoms affect work, sleep, or activities: _____

Treatments Tried

Medical grade compression stockings (20-30 mmHg), in the last 3 months: ☐ Yes ☐ No

Recommended by: ☐ Self ☐ Provider

How long have you tried/worn compression (months/years): _____

How often (all day/part of the day): _____

Pain relievers tried: ☐ Tylenol/acetaminophen ☐ Advil/Motrin/Ibuprofen ☐ Aleve/Naproxen ☐ Aspirin

☐ Prescription(s) (name): _____

How long have you used the pain relievers (daily/sometimes/as needed): _____

Other methods: ☐ Rest ☐ Elevation ☐ Weight loss ☐ Ice ☐ Heat ☐ Massage/Lotions/Creams ☐ Exercise

Relief from compression/medicine/other methods: ☐ No ☐ Sometimes ☐ Very little

Prior vein and Circulation history

History	Response
History of blood clot/DVT (in leg[s])	☐ No ☐ Right ☐ Left
Bleeding from a vein	☐ No ☐ Right ☐ Left
Prior vein surgery or ablation	☐ No ☐ Yes Type/Date: _____
Prior sclerotherapy	☐ No ☐ Yes Date: _____
Family history of varicose/spider veins	☐ No ☐ Yes ☐ Unknown

If yes, which relative(s): _____

☐ Maternal side ☐ Paternal side ☐ Both

Patient Signature _____ Date _____

2. CURRENT MEDICATIONS

Include prescriptions, over-the-counter medicines, vitamins, supplements, and blood thinners. Please use an extra sheet of paper if needed.

Medication	Dose	How often

3. ALLERGIES (Please use an extra sheet of paper if needed)

Drug/Medication Allergies: _____ Reaction(s): _____

Other Allergies: _____ Reaction(s): _____

4. SOCIAL HISTORY

Social history	Response
Alcohol use	☐ Never ☐ Rarely ☐ Occasionally ☐ Daily
Exercise	☐ Never ☐ Occasionally ☐ Daily Type: _____
Smoking/tobacco	☐ Never ☐ Former ☐ Current Quit date: _____ Amt/day: _____
Vaping/e-cigarettes	☐ Never ☐ Former ☐ Current Quit date: _____ Amt/day: _____
Do you fly regularly	☐ No ☐ Yes If yes; how often: _____

5. MEDICAL HISTORY/REVIEW OF SYSTEMS (Please use an extra sheet of paper if needed)

Diagnosed conditions: ☐ Heart disease ☐ High blood pressure ☐ Diabetes ☐ HIV ☐ Hepatitis ☐ Cancer

☐ Kidney disease ☐ Varicose veins ☐ Other: _____

Lightheadedness/fainting with procedures or blood draws: ☐ Yes ☐ No ☐ Unknown

Surgical history and approximate dates (mm/yyyy): _____

6. Pelvic symptoms and Pregnancy (patients with female reproductive organs)

Answer only if these questions apply to you. You may select prefer not to answer.

Question	Response
Pregnant or planning to become pregnant:	☐ Yes ☐ No ☐ Unsure ☐ N/A
Currently breastfeeding:	☐ Yes ☐ No ☐ N/A
Pelvic aching, heaviness, or dragging, especially around menstrual cycle:	☐ Yes ☐ No ☐ N/A
Irritable bladder or stress incontinence around menstrual cycle:	☐ Yes ☐ No ☐ N/A
Irritable bowels around menstrual cycle:	☐ Yes ☐ No ☐ N/A
Discomfort during sexual intercourse:	☐ Yes ☐ No ☐ Prefer not to answer
Bulging veins around vagina/vulva, especially around menstrual cycle:	☐ Yes ☐ No ☐ Unsure
Visible small varicose veins at upper inner thigh, vulva, buttock crease, anus, or perineum:	☐ Yes ☐ No ☐ Unsure

Patient Signature _____ Date _____

7. Health Screening History

Most recent mammogram (mm/yyyy): _____ Facility: _____

Result: ☐ Normal ☐ Abnormal ☐ Unknown

Mastectomy: ☐ No ☐ Yes ☐ N/A Date: _____ Side: ☐ Right ☐ Left ☐ Bilateral

Still require mammogram: ☐ No ☐ Yes ☐ N/A

Most recent colonoscopy/fecal occult blood test (mm/yyyy): _____ Facility: _____

Result: ☐ Normal ☐ Abnormal ☐ Unknown

Colectomy/colon surgery: ☐ No ☐ Yes Date (mm/yyyy): _____

Still require colonoscopy: ☐ No ☐ Yes ☐ N/A

****STOP HERE, BUT PLEASE STILL SIGN THE BOTTOM OF THE PAGE****

PROVIDER USE ONLY - PHYSICAL EXAMINATION

Document observations used in the PHYSICAL EXAMINATION portion of the appointment.

Finding	Right	Left	Both	Notes
Visible/tortuous veins	☐	☐	☐	_____
Tender veins	☐	☐	☐	_____
Edema/swelling	☐	☐	☐	_____
Skin staining/dyscoloration	☐	☐	☐	_____
Open wound/ulcer	☐	☐	☐	_____
Cellulitis/calf tenderness	☐	☐	☐	_____
Compression stocking relief: ☐ No ☐ Some ☐ Very little				_____
Did you receive the Covid Vaccine: ☐ Yes ☐ No				_____

Pedal pulses: Right _____ Left _____

Additional examination notes: _____

Patient confirmation

I have answered these questions as completely and accurately as I can. I understand that my care team may review or clarify my answers with me.

Patient Signature _____ Date _____