PATIENT NAME:_____ **DATE:** _____

You are being evaluated for potential treatment of varicose veins in one or both legs. Please complete this questionnaire to indicate how your varicose veins are affecting your leg(s).

SYMPTOMS

What Symptoms do you have in your legs?
Please circle the symptoms below:

Achiness	Swelling	Pain	Throbbing	Itchiness	Bruising
Recurrent Ulceration	Recurrent DVT/SVT	Protruding Varicose Veins	Bleeding Varices	Spider Veins	Discoloration

Where are the locations of these symptoms in your legs?
_____
How long have you had these symptoms?
_____

ACTIVIES OF DAILY LIVING

What is the effect your varicose veins have on your ability to work or perform your usual daily activities?

No Effect	
Full work/activity but have symptoms	
Mildly reduced work/daily activity	
Moderately reduced work/daily activity	
Severely reduced work/daily activity	
Unable to do work/daily activity	

What activities of daily living (ADL) are you unable to perform due to your pain?
▫ Sleeping ▫ Walking ▫ Standing ▫ Sitting ▫Running ▫ Working ▫ School
▫ Bathing ▫ Showering ▫ Dressing ▫ Shoes ▫ Toileting ▫ Cleaning ▫ Desk Work
▫ Self Care ▫ Family Care ▫ Child Care ▫ Home Care ▫ Driving ▫ Gardening ▫ Lifting

Describe how the pain affects these Activities of Daily Living (ADL):
_____
_____
Are you able to exercise without pain from varicose veins?
_____
What were you able to do but are unable to do now due to your varicose veins?
_____
_____

HISTORY

Are you wearing or have you ever worn compression stockings? _____

If yes, for how long? _____ What is or what was the strength?

_____

Did you find any relief?

_____

Are you taking any pain medicine to relieve the pain or the discomfort in your legs?

▫ No ▫ Yes (If yes, specify type of medication and how often:

_____)

Have you had recent weight gain or weight loss? _____ How many pounds?

_____

Do you have to elevate your legs to relieve symptoms temporarily?

How often? _____ When during the day?

_____