**DATE:** _____

**PATIENT NAME:** _____

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?** ☐ No ☐ Yes If yes, how many pounds? _____
**Do you have to elevate your legs to relieve symptoms temporarily?** ☐ No ☐ Yes
**If yes:** How often? _____ When during the day? _____