

VIEN CLINIC QUESTIONNAIRE

PATIENT NAME: _____ **D.O.B.** _____

	YES	NO
DO YOU HAVE VARICOSE VEINS, VENOUS INSUFFICIENCY OR ANY SYMPTOMS LISTED BELOW?	___	___

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS RELATED TO YOUR LEGS:

- | | | |
|--|-----|-----|
| • THROBBING OR ACHING PAIN IN YOUR LEGS | ___ | ___ |
| • LEG CRAMPS | ___ | ___ |
| • FEELING OF HEAVINESS IN YOUR LEGS | ___ | ___ |
| • FATIGUE OR TIREDNESS IN YOUR LEGS | ___ | ___ |
| • ITCHING OR BURNING IN YOUR LEGS | ___ | ___ |
| • RESTLESS LEGS | ___ | ___ |
| • SWOLLEN ANKLES OR LEGS | ___ | ___ |
| • DO YOU HAVE ANY ULCERS OR SKIN COLOR CHANGES ON YOUR LEGS OR ANKLE AREA? | ___ | ___ |
| • DO YOU EXPERIENCE ANY PAIN IN YOUR LEGS WHILE WALKING? | ___ | ___ |