VEIN 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?	___	___