# Vein Questionnaire

Date_____ Patient phone #_____

Patient Name_____ Date of birth_____

| | | |
|---|---|---|
| *Do your legs ache, hurt or feel heavy?* | ____*Yes* | ____*No* |
| *Do your legs swell? (sock lines)* | ____*Yes* | ____*No* |
| *Do your legs cramp or throb?* | ____*Yes* | ____*No* |
| *Do your legs have visible veins?* | ____*Yes* | ____*No* |
| *Is there family history of vein disease?* | ____*Yes* | ____*No* |
| *Do you have any skin changes?* | ____*Yes* | ____*No* |
| *Do your legs itch or burn?* | ____*Yes* | ____*No* |
| *Do you have restless legs?* | ____*Yes* | ____*No* |
| *Are there activities you no longer do because of leg pain?* | ____*Yes* | ____*No* |
| *Are you in a standing occupation?* | ____*Yes* | ____*No* |

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**Form reviewed by** _____ **Date**_____

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