



Vein Treatment Institute

of Bucks County

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VARICOSE VEIN QUESTIONNAIRE

Your answers to the questions below will help guide therapy and may help determine whether your treatment is covered by certain insurance plans.

Name: _____ Age: _____ Gender: M F

1. I have the following concerns regarding my legs and leg veins: (Check all that apply)

	<i>R Thigh</i>	<i>L Thigh</i>	<i>R Calf</i>	<i>L Calf</i>	<i>R Ankle</i>	<i>L Ankle</i>
Large Bulging Varicose Veins						
Pale Blue Reticular Veins						
Red/Purple Spiders Veins						
Pain/Burning in Veins						
General Aching/Heaviness						
Swelling						
Skin Discoloration / Rash						
Phlebitis						
Prior Bleeding						
Leg Ulcers (Active or Healed)						

2. My vein problems : ___ Are a cosmetic concern **ONLY** ___ Are painful
 ___ Limit my ability to enjoy activities ___ Limit my ability to work

3. Pain Medications Taken for Varicose Vein Symptoms in last 3 months (incl. narcotics, Advil etc.):

Medications: _____ For How Long? _____ Months

4. Previous Vein Treatment/Surgery: _____ R / L

5. Do you wear or have you worn prescription-grade Compression Stockings?

___ YES For how long? _____ Helpful? Yes / Only Partially / No
 ___ NO Why Not? ___ Never prescribed ___ Uncomfortable ___ Unsightly

6. History of DVT (Deep Vein Thrombosis / Blood Clot) : Right Leg / Left Leg

7. History of Miscarriage : Yes / No

8. Family History of Pulmonary Embolism or DVT (Blood Clots) : Yes / No