

**Vein Questionnaire**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Blood Type \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Referred by \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**Please circle all that applies:**

**PERSONAL MEDICAL HISTORY (CURRENT COMPLAINT)**

1. Are you consulting for  
Cosmetic purposes \_\_\_\_\_ Medical reasons \_\_\_\_\_
  
2. How many years have you noticed this problem? \_\_\_\_\_ x year
  
3. Have you ever been treated for this problem? Yes / No  
By whom \_\_\_\_\_ When? \_\_\_\_\_  
With what method?  
Injection \_\_\_\_\_ Electrocautery \_\_\_\_\_ Laser \_\_\_\_\_ Surgery \_\_\_\_\_
  
4. Have you ever been treated for one of the following?

Phlebitis (inflammation of a vein)	Yes / No	R / L leg	Hospitalization _____	When? _____
Leg ulcer	Yes / No	R / L leg	Hospitalization _____	When? _____
Pulmonary embolism/blood clots	Yes / No	R / L leg	Hospitalization _____	When? _____
Leg fracture	Yes / No	R / L leg	Hospitalization _____	When? _____
  
5. When did your veins occur?  
Age \_\_\_ Before/During/After pregnancy \_\_\_ After trauma \_\_\_ After birth control \_\_\_ Hormonal Therapy
  
6. Are you developing new veins? Yes / No
  
7. Are your present veins getting bigger? Yes / No - More noticeable? Yes / No - More painful?- Yes / No
  
8. Indicate which of the following problems you have experienced:

	Right left	Left leg	How many years?
a. Pain in your			
Lower limbs	_____	_____	_____
Thigh	_____	_____	_____
Calf	_____	_____	_____
Leg	_____	_____	_____
Foot	_____	_____	_____
b. Swelling of the legs	_____	_____	_____
c. Skin or ulcer problems	_____	_____	_____
d. Others	_____	_____	_____
Specify _____			
  
9. Does walking or exercise relieve or aggravate the pain? \_\_\_\_\_
  
10. Do you jog, run, jump rope or do aerobics? Yes / No      How often per week? \_\_\_\_\_

11. Are you pregnant or planning a pregnancy soon? Yes / No  
12. Number of past pregnancies and years of births \_\_\_\_\_

13. Date of last menses \_\_\_\_\_

14. Do you smoke cigarettes? Yes / No If yes, how many packs per day? \_\_\_\_\_  
How many years have you smoked? \_\_\_\_\_

15. Do you wear elastic support stockings? Yes / No What kind? \_\_\_\_\_  
How often? \_\_\_\_\_

16. Have you ever had a blood transfusion? Yes / No If yes when? \_\_\_\_\_

17. If you experience pain in your lower limbs:

	No	Yes
a. Is the pain exacerbated by		
Extended period in standing position	_____	_____
Heat	_____	_____
Menstrual periods	_____	_____
Exercising and/or walking	_____	_____
Medication	_____	_____
Others	_____	_____
b. Is the pain alleviated by		
Elevation of the limb	_____	_____
Elastic stockings	_____	_____
Walking and/or exercising	_____	_____
c. Indicate the type of pain		
Pain at rest	_____	_____
Resting cramping	_____	_____
Night cramps	_____	_____
Tiredness	_____	_____
Heaviness in the legs	_____	_____
Pain in specific areas	_____	_____
Numbness	_____	_____
Burning sensation	_____	_____
Additional comments _____		

	No	Yes
18. Do you have a family history of		
a. Varicose veins problems		
Family Member _____	_____	_____
b. Phlebitis (inflammation of the vein)		
Family Member _____	_____	_____
c. Blood clots		
Family Member _____	_____	_____
d. Leg ulcers		
Family Member _____	_____	_____
e. Cancer		
Family Member _____	_____	_____

\_\_\_\_\_ Patient initial

19. Do you have a personal history of allergies to medications? If so, please list

	No	Yes
a. Allergies to any foods?	_____	_____
b. Allergies to nail polish?	_____	_____
c. Allergies to cosmetics?	_____	_____
d. Allergies or sensitivity to adhesive tape?	_____	_____

20. Do you have a history of:

	No	Yes
Diabetes	_____	_____
High blood pressure	_____	_____
Seizures or convulsions	_____	_____
Fainting or dizzy spells	_____	_____
Stroke	_____	_____
Blood transfusions	_____	_____
Asthma	_____	_____
Hives	_____	_____
Arthritis	_____	_____
Thrombophlebitis	_____	_____
Pulmonary embolus	_____	_____
Deep vein thrombosis	_____	_____
Septicemia	_____	_____
Autoimmune disease (i.e. Lupus)	_____	_____
Hepatitis	_____	_____
Bleeding disorders	_____	_____
Easy bruisability	_____	_____
Heart disease	_____	_____
Migraine headaches	_____	_____
Dark spots after pregnancy, skin injury or surgery	_____	_____
HIV positive (AIDS test)	_____	_____

21. Are you taking any medication? Yes / No

Indicate which of the following you are taking:

	No	Yes
a. Aspirin	_____	_____
b. Anticoagulants	_____	_____
c. Hormones or contraceptives (birth control pills)	_____	_____
d. Chemotherapy for any type of tumor	_____	_____
e. Thyroid medication	_____	_____
f. Cortisone	_____	_____
g. Insulin	_____	_____
h. Sedatives (sleeping pills)	_____	_____
i. Tranquillizers	_____	_____
j. Appetite depressants	_____	_____
k. Others	_____	_____
Specify _____		

\_\_\_\_\_ Patient initial

