Vein Questionnaire
Evansville Regional Vein Center

Name _____ **Date of Birth** _____ **Date** _____

Age _____ **Gender** Male Female

Were you referred to us by a doctor? Yes No Doctor's name: _____
Who is your family physician? _____

If not, how did you first hear of us? (Check all that apply): □TV □Radio □ Internet Search □ Physician
□ Family/Friend: Who? _____ □ Website □ Newspaper □ Social media _____ □ Other _____

Tell Us About Your Vein Problems:

Describe the problems you have with your legs and/or veins: _____
_____
_____
_____
_____
_____

Do you have bulging veins? Yes No Do you have spider veins? Yes No

How many years have you had vein problems? _____

What is/was your occupation? _____

Do you have any varicose veins on your lower abdomen or groin area? Yes No

Do you take the medication minocycline (Minocin)? Yes No

Women: How many children have you delivered? _____

Have you had two or more miscarriages? Yes No

Did your pregnancies cause any vein problems? Yes No

Do you have any pelvic or vaginal varicose veins? Yes No

Have you delivered a baby within the last 60 days? Yes No

Is there any chance that you could currently be pregnant? Yes No

Men: Do you have a varicocele (large varicose vein in scrotum)? Yes No

Have you ever worn prescription compression hose for your veins? Yes No

How long did you wear them? _____

What effect did they have on your symptoms? _____

Regarding your legs, do you have?

Resting pain …….. Yes No
Resting cramps ……..Yes No
Night cramps ……..Yes No
Tiredness ……Yes No
Heaviness ……...Yes No
Numbness ……Yes No
Burning sensation ……Yes No
Restless legs ……..Yes No
Itching ……..Yes No
Swelling of ankles ……..……...Yes No
Pigmentation changes …….Yes No

How are your leg problems affected by the following:

Elevation of your legs …… Better Worse No change
Prolonged periods of standing ……..Better Worse No change
Prolonged periods of sitting …….. Better Worse No change
Exposure to heat …… Better Worse No change
Walking or exercising ……Better Worse No change
Taking pain medication (prescription or non-prescription) Better Worse No change
Losing weight (if you are overweight) ……..Better Worse No change
Having a menstrual period …… Better Worse No change

Have you ever had any of these problems?

Deep vein blood clot (DVT) …….. Yes No
Pulmonary embolism (lung blood clot) ……Yes No
Blood clotting disorder ……..…… Yes No
Superficial vein blood clots ……Yes No
Bleeding from your veins ……Yes No
Dermatitis (eczema) (rash) on lower leg…..... Yes No
Leg ulcers ……Yes No
Surgery on your legs …….. Yes No
Trauma (injury) to your legs ……Yes No

Some insurance companies require information on how your vein problems interfere with the quality of your life or with your ability to perform the normal activities of daily living such as walking, working, gardening, playing with your children/grandchildren, having to stop activities in order to elevate your legs, etc. Please tell us how your veins affect your life (please do not include issues of appearance).

_____

_____

_____
_____
_____
_____

Have you had treatments for your veins in the past? Yes No

What treatments? _____

When were they done? _____

Physician or facility performing treatment? _____

Medical History:

Besides vein problems, what medical conditions/diseases/problems do you have? _____
_____
_____
_____
_____
_____
_____

What medications do you take (include all non-prescription medications and supplements)? _____
_____
_____
_____
_____
_____
_____

Are you allergic to any medications? Yes No What? _____

Family History:

Do any family members have varicose veins? Yes No

Who? _____

Have any family members had a deep vein blood clot (DVT) or a pulmonary (lung) blood clot?

Yes No Who? _____

Do any family members have a blood clotting problem?

Yes No Who? _____