Richard S. York, MD
Vein & Laser Clinic

VARICOSE VEIN QUESTIONARE

Name_____ Today's Date_____

Birthdate_____ Referring Doctor_____

Occupation_____

Chief Complaint (reason for seeking medical attention):

- ❑ **Varicose veins (bulging, rope-like veins)**
- ❑ **Spider veins (fine veins on skin surface)**
- ❑ **Other, please describe** _____

I. Do you have or have you had:

Unsightly veins	❑ yes ❑ no ❑ right ❑ left	Aches or Pain in legs	❑ yes ❑ no ❑ right ❑ left
Heaviness or Tired Legs	❑ yes ❑ no ❑ right ❑ left	Ankle Swelling	❑ yes ❑ no ❑ right ❑ left
Itching in legs	❑ yes ❑ no ❑ right ❑ left	Night Cramps in legs	❑ yes ❑ no ❑ right ❑ left
Bleeding from Veins	❑ yes ❑ no ❑ right ❑ left	Pigmentation (Discoloration) in Legs	❑ yes ❑ no ❑ right ❑ left
Dermatitis (rash of the skin)	❑ yes ❑ no ❑ right ❑ left	Ulceration (Open Sores) on legs	❑ yes ❑ no ❑ right ❑ left
Pulmonary emboli (blood clot in lungs)	❑ yes ❑ no	Burning restless legs	❑ yes ❑ no ❑ right ❑ left

Superficial phlebitis of legs (skin over vein becomes red, warm & tender) ❑ yes ❑ no ❑ right ❑ left

Deep Thrombo-phlebitis (blood clot in leg) ❑ yes ❑ no ❑ right ❑ left

Which leg is worse? ❑ right ❑ left

Any previous ultrasound of legs ❑ yes ❑ no When & Where_____

II. Previous Vein Treatments (mark all that apply):

❑ Compression Stockings: ❑panty hose, ❑thigh highs, or ❑knee high ❑prescription or ❑over the counter
How Often & When_____

❑ Sclerotherapy (injections) ❑ right ❑ left

❑ Vein Stripping (surgery) ❑ right ❑ left
When:_____
Incision at groin: ❑ yes ❑ no
Other Incision location:_____

❑ Local Varicose Vein Removal/Excision (phlebectomy)

❑ Other procedures – EVLA "Laser Closure" ❑ right ❑ left
When & with whom:_____

III. Most insurance companies require documentation of any medication taken for discomfort, when considering coverage of varicose veins treatment. Please list any medication you have ever taken for leg ache, including prescription and over-the-counter medicines (such as Tylenol, ibuprofen, naprosyn, celebrex, motrin, aspirin, and others)

_____

_____

Other Medical History:

List any other previous surgery:

Year	Operation

Mark any condition you have or have had in the past:

- ❑ Stroke
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Anemia
- ❑ HIV Infection
- ❑ Hepatitis
- ❑ Alcoholism
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ Thyroid Disease
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Hypertension (high blood pressure)
- ❑ Lung Disease
- ❑ Liver Disease
- ❑ Prostate Problems
- ❑ Cancer – Type_____
- ❑ Psychiatric Care
- ❑ Bleeding or blood disorders
- ❑ Injury to Leg ❑ right ❑ left

List any other serious illness or injury with approximate date:

_____

_____

_____

List all medications that you are currently taking:

Medication	Dosage	Frequency

Allergies: ❑ None

_____

_____

_____

Health Habits: Check substances you use, and describe how much

- ❑ Tobacco _____
- ❑ Alcohol _____
- ❑ Recreational Drugs _____
- ❑ Other_____

Family History

Is there a family history of varicose veins? ❑ Yes ❑ No Is there a family history of blood clots? ❑ Yes ❑ No

Other

Do your vein symptoms adversely affect your life? ❑ Yes ❑ No

If so, how? _____

What activities cause leg pain and what brings relief?

_____

_____

_____

_____

_____