

Alaska Vein Clinic Vein Questionnaire



Thank you for visiting the Alaska Vein Clinic. Please answer all the questions the best you can. If you are not sure of any answer just write a question mark next to the item.

Name _____ Date _____

1. How long have you had varicose veins? _____

2. What bothers you the most?

1. Symptoms	<input type="checkbox"/>
2. Appearance	<input type="checkbox"/>

3. Allergies:

	Yes	No
Betadine Paint or Scrub? (Contains Iodine)	<input type="checkbox"/>	<input type="checkbox"/>
Valium?	<input type="checkbox"/>	<input type="checkbox"/>
Lidocaine or Marcaine?	<input type="checkbox"/>	<input type="checkbox"/>

4. Medications (Check all that apply):

Plavix	<input type="checkbox"/>
Coumadin	<input type="checkbox"/>
Oral Contraceptives	<input type="checkbox"/>
Hormone Replacement	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>
Heparin	<input type="checkbox"/>

5. When Did You First Notice Varicose Veins?

	Yes	No
Before Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
During Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
After Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
After trauma / injury?	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

6. Life Style:

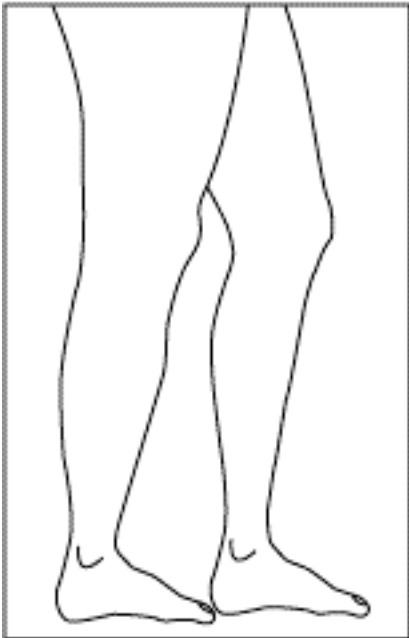
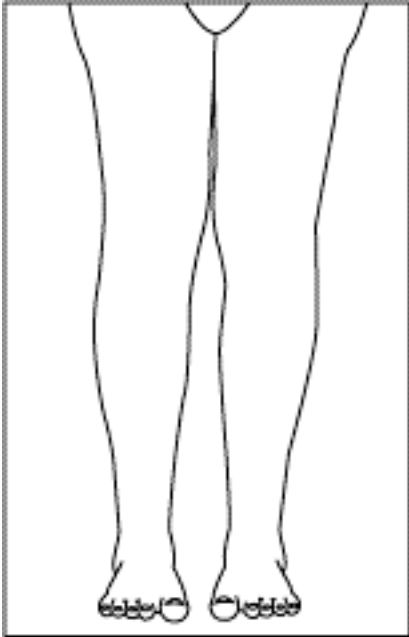
	Yes	No
Are your symptoms interfering with daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take pain medication for relief of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Do you elevate your legs to relieve your discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
Does exercise help your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take pain medication for relief of symptoms? If so, list here: _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your symptoms worse at the end of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Are your symptoms made worse by prolonged standing?	<input type="checkbox"/>	<input type="checkbox"/>

7. Symptoms:

In which leg do you have the following symptoms?	Right	Left
Aches and Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness and Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Night cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding from veins	<input type="checkbox"/>	<input type="checkbox"/>

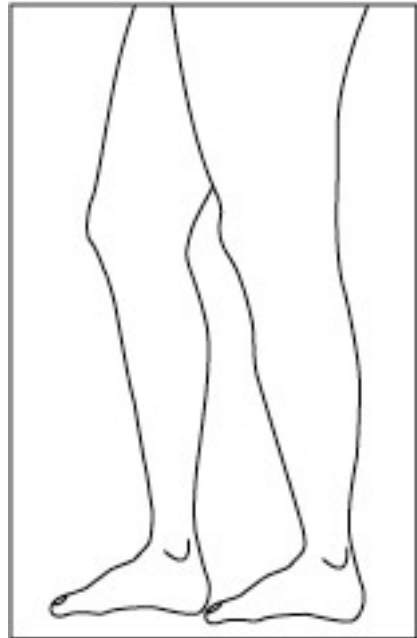
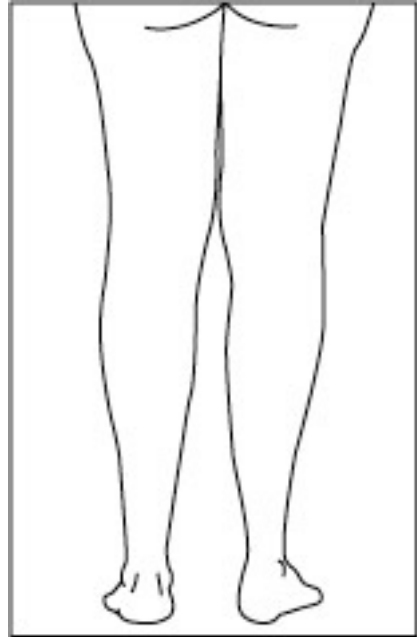
Name _____

Front



Right Outer/Left Inner

Back



Right Inner/Left Outer

Please circle areas where you have vein problems.

Name _____

8 . Prior Vein Treatment

Please describe any prior varicose vein treatment	Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>
Saphenous vein stripping	<input type="checkbox"/>	<input type="checkbox"/>
Laser ablation	<input type="checkbox"/>	<input type="checkbox"/>
Radiofrequency ablation	<input type="checkbox"/>	<input type="checkbox"/>
Local excision of individual varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy (injections)	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

9. Support Hose

	Yes	No
Do you wear prescription medical support stockings? If so, for how long? _____	<input type="checkbox"/>	<input type="checkbox"/>
If you have stopped or refused to wear support hose please state why: _____ _____ _____ _____ _____ _____		

Name _____

10. Clotting History

Do you have a previous history of any of the following?	Yes	No
Superficial thrombophlebitis?	<input type="checkbox"/>	<input type="checkbox"/>
Deep venous thrombosis?	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophilia disorder (Factor V Leiden mutation, etc) If so, name disorder: <hr/>		
Easy bruisability	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>

11 . Medical Issues pertaining to Varicose Vein Treatment

Do you have a previous history of any of the following?	Yes	No
Migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Atrial or ventricular septal defect?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or TIA?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>
Transient vision loss?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty lying flat for more than one hour?	<input type="checkbox"/>	<input type="checkbox"/>

12. Additional Information or Comments

Name _____