

# Katy Pain & Spine

## Vein Screening Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Do you have or have you ever been diagnosed with:**

Varicose vein problems       Y    N      Leg:  R    L  
Leg or Ankle Ulcers         Y    N      Leg:  R    L  
Spider Veins                 Y    N      Leg:  R    L

**Do you experience any of the following in your leg(s):**

Aching/pain                 Y    N      Leg:  R    L  
Heaviness                  Y    N      Leg:  R    L  
Tiredness/fatigue         Y    N      Leg:  R    L  
Itching/burning           Y    N      Leg:  R    L  
Swelling                   Y    N      Leg:  R    L  
Cramps                      Y    N      Leg:  R    L  
Restless legs              Y    N      Leg:  R    L  
Throbbing                  Y    N      Leg:  R    L  
Skin or ulcer problems     Y    N      Leg:  R    L

**Do you do any of the following to improve the discomfort in your leg(s)?**

Take Medication for pain     Y    N      What? \_\_\_\_\_

Elevate your legs             Y    N      What? \_\_\_\_\_

Wear support hose           Y    N      What? \_\_\_\_\_

**Personal and Family History:**

Does anyone in your family have Varicose Veins?     Y    N      If so who? \_\_\_\_\_

Have you ever been pregnant?     Y    N      If so how many times? \_\_\_\_\_

Do you sit or stand for long periods of time?     Y    N      For how long? \_\_\_\_\_

Do you exercise regularly?     Y    N      How often? \_\_\_\_\_