Mass Vein Care

Initial Visit Questionnaire

Name:_____ **Date:**_____

Birthdate:_____ **Age:**_____

Primary Care Physician:_____
PCP Address:_____

Did your PCP refer you here? ☐ **Yes** ☐ **No**

Insurance Plan and Number:_____

Current Problem

1. Do you experience any of the following symptoms in your legs? (please check)

☐ aching/pain
Please rate this pain, 1 being painless, 10 being incredibly painful:____

☐ heaviness ☐ numbness/tingling ☐ tiredness/fatigue ☐ itching/burning

☐ swollen ankles ☐ leg cramps ☐ restless legs ☐ throbbing ☐ tenderness

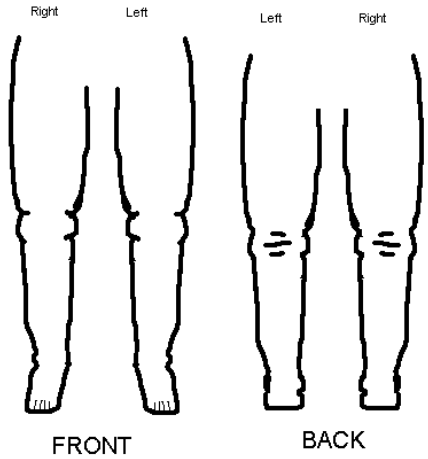
☐ warm leg ☐ red leg ☐ abnormally large veins ☐ other:_____

2. Do you experience these symptoms in the right leg, left leg or both?_____
If on both sides, which leg is worse**?**_____

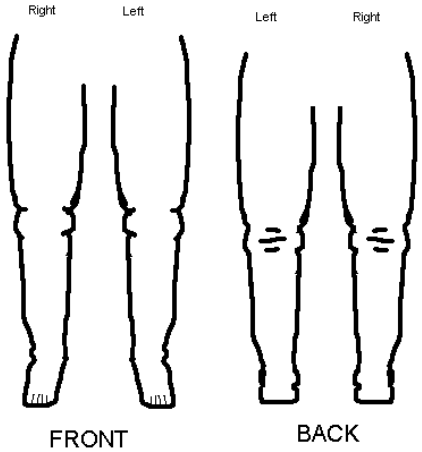
3. How often do you have these symptoms? ☐ Constantly ☐ Most of the time
☐ Sometimes ☐ Almost never/ Never

4. Please mark the following areas with "x" on the drawings below:

Symptomatic areas



Areas of Cosmetic Concern



5. How much do your symptoms restrict your activity?

☐ I can do frequent vigorous exercise (running, heavy lifting, strenuous sports)
☐ I am limited to moderate activity (moving a table, vacuuming, bowling, golf)
☐ I can't do more than regular walking (short errands away from home) because of my vein symptoms
☐ I can only do occasional walking (room to room, going to mailbox) because of my vein symptoms
☐ I can hardly walk at all (mainly sit or lie down) because of my veins

6. Have your veins gotten worse in recent months? ☐ Yes ☐ No
<u>IF YES</u>, how much has your activity been reduced <u>in the past 4 weeks</u>?

☐ I can do frequent vigorous exercise (running, heavy lifting, strenuous sports)
☐ I am limited to moderate activity (moving a table, vacuuming, bowling, golf)
☐ I can't do more than regular walking (short errands away from home) because of my vein symptoms
☐ I can only do occasional walking (room to room, going to mailbox) because of my vein symptoms
☐ I can hardly walk at all (mainly sit or lie down) because of my veins

7. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No

8. Do you wear compression stockings prescribed by your doctor? ☐ Yes ☐ No

9. Do you wear light support stockings (e.g. Sheer Energy)? ☐ Yes ☐ No

10. Do support or compression stockings provide relief? ☐ Yes ☐ No ☐ N/A

11. Do you have any problem walking? ☐ Yes ☐ No

If so, how far can you walk? ☐ Not limited ☐ Greater than 5 blocks
☐ Less than 5 blocks ☐ Less than 1 block

12. Do you stand much at home? ☐ Yes ☐ No at work? ☐ Yes ☐ No

If so, how does standing affect your legs? _____

Past Medical History

13. Venous History

Have you ever had your veins evaluated before? ☐ Yes ☐ No
If yes, when and where? _____

Have you ever had any tests done on your veins? ☐ Yes ☐ No
If yes, please describe: _____

Have you ever had vein stripping surgery? ☐ Yes ☐ No
If yes, when and which leg? _____

Have you ever had vein injections? ☐ Yes ☐ No
If yes, when, where and which leg? _____

Have you ever had a blood clot? ☐ Yes ☐ No

If yes, which leg and when? _____

Have you ever had phlebitis? ☐ Yes ☐ No
If yes, which leg and when? _____

14. General Medical History

Please list any hospitalizations you have had: _____
_____

Please list any surgeries you have had: _____
_____

Have you had surgery requiring a prosthetic device? Yes No

Do you take antibiotics prior to dental appointments? Yes No

Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, for what illness or purpose? _____

Do you have…
☐ heart disease ☐ lung disease ☐ high blood pressure ☐ hepatitis
☐ arthritis ☐ leg ulcer

15. Do you smoke? ☐ Yes ☐ No
If yes, how many packs per day? _____

16. Medications

Do you take any blood-thinning medications? ☐ Yes ☐ No ☐ Not sure
Do you take any hormones or birth control pills? ☐ Yes ☐ No ☐ Not sure

Please list all the medications that you take:_____
_____
_____
_____

17. Allergies

Please list any allergies you have and describe the reaction: _____
_____
_____

18. Child-Rearing History

Do you think you are currently pregnant? ☐ Yes ☐ No
Do you intend to have any more children? ☐ Yes ☐ No
How many times have you been pregnant? _____
When was the last time you were pregnant? _____

19. Family History

Has anyone in your family had varicose veins or spider veins?
Father ☐ Yes ☐ No Mother ☐ Yes ☐ No
Brother(s) ☐ Yes ☐ No Sister(s) ☐ Yes ☐ No
Other(s):_____