SWEDISH
MEDICAL GROUP

Vein Questionnaire

Please answer the following questions

Accredited Vascular Laboratory — IC AVL — Intersocietal Commission for the Accreditation of Vascular Laboratories

Do your daily activities require prolonged periods of sitting or standing?

If yes, check all that you have difficulty doing daily:

☐ Cleaning ☐ Working ☐ Gardening

☐ Walking ☐ Sleeping ☐ Taking care of Kids

☐ Running ☐ Climbing ☐ Sitting

☐ Relaxing ☐ Standing ☐ Bathing

☐ Cooking ☐ Driving

☐ Other (please be specific): _____

_____

Do you experience any of the following symptoms in your legs? If yes, please check all that apply.

☐ Aching ☐ Throbbing ☐ Cramping ☐ Ulceration ☐ Burning

☐ Itching ☐ Heaviness ☐ Swelling ☐ Tightness ☐ Bleeding

☐ Dry, red or pigmented skin

Do you take over-the-counter medications (e.g., aspirin, ibuprofen, NSAIDS or a similar type of medication) or prescription medications for aching, cramping, burning or swelling of the lower extremities?

If yes, what is the medication and dosage? _____

If yes, how many days in a *two week period* of time did the patient take the medication?

☐ 0 - 2 days ☐ 3 - 4 days ☐ 5 - 6 days ☐ 7 or more days

Have you used compression stockings? A minimum of three-months?

☐ Yes ☐ No ☐ Yes ☐ No

What Strength of stockings (in mmHg) have you worn? Please check: ☐ 8-15 ☐ 20-30 ☐ 30-40

If yes, did they result in a significant improvement in symptoms? _____

Patient Name: _____ Date: _____

Patient Signature: _____