Vein Questionnaire
Please answer the following questions

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: __________________________________________