# VARICOSE VEIN QUESTIONNAIRE

**PATIENT NAME:_____**
**DATE OF BIRTH:_____**
**TODAY'S DATE:_____**

1.) How long have you had varicose veins? _____

2.) Do you suffer from:
__Cramping
__Pain
__Swelling
__Ulcers

3.) Please explain how varicose veins effect your lifestyle.
_____
_____
_____
_____
_____
_____

4.) Do you have a history of blood clots? _____

5.) Do you have a family history of varicose veins? _____

6.) Have you ever worn compression stockings? _____
If yes,
When? _____
What type?_____

7.) Do you take Tylenol or other anti-inflammatory medications?_____
If yes, how much and how often?_____

8.) Do you elevate your legs?_____
If yes, how long and how often?_____

Please list any other treatment you have received for your varicose veins.
_____
_____
_____
_____
_____