NORTH SHORE VEIN CENTRE
Healthier Legs for Living!
A subsidiary of North Shore Cardiology Consultants

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PATIENT QUESTIONNAIRE
VEIN HISTORY AND MEDICAL NECESSITY

Name _____ **Date** _____

PLEASE CHECK ALL THAT APPLY

1. Which of the following are causing you concern?)
   ☐ **Spider Veins** ☐ **Bulging Varicose Veins** ☐ **Leg swelling/edema** ☐ **Restless leg(s)**
2. How long have your veins symptoms been a problem? _____ ☐ Months ☐ Years
3. Do your veins limit your daily activities due to discomfort? ☐ YES ☐ NO
4. Does prolonged sitting or standing aggravate your veins? ☐ YES ☐ NO
5. Have you ever noticed any of the following occur during activity or after prolonged standing?
   ☐ **Aching** ☐ **Fatigue** ☐ **Swelling** ☐ **Itching** ☐ **Pain** ☐ **Burning**
   ☐ **Exercise intolerance** ☒ **Feeling of heaviness** ☐ **Skin changes**
6. Have you ever had any of the following?
   ☐ **Bleeding from a spider vein** ☐ **Slow or non-healing skin ulceration** ☐ **Phlebitis**
   ☐ **Significant, recurrent superficial phlebitis** ☐ **Darkening of the skin** ☐ **Leg ulceration**
7. Have you ever been treated for ulcerations or a blood clot in your leg? If yes, when and which leg? What was done?
   _____
   _____
8. Have you ever had therapy for leg vein problems (including laser treatment, sclerotherapy and/or vein stripping)? If yes, when and which leg? What was done?
   _____
   _____
9. Do you have a family history of any of the follow?
   ☐ **Vein disease** ☐ **Leg ulcerations** ☐ **blood clots**
10. Are you allergic to Lidocaine? ☐ YES ☐ NO
11. How have you attempted to manage your varicose vein symptoms? ☐ **Attempted weight loss**
    ☐ **Compression Stockings** *(how long have you worn them _____)* ☐ **Exercise**
    ☐ **Leg elevation** ☐ **Medications (Motrin, aspirin, etc.)** _____
12. Do you experience any of the following symptoms?
    ☐ **Chest pain** ☐ **Shortness of Breath** ☐ **Prolonged Bleeding** ☐ **Fevers**
    ☐ **Chronic Cough** ☐ **New onset of leg swelling** ☐ **Fainting Easily** ☐ **Stroke**
13. Past medical conditions: ☐ **Heart Disease** ☐ **Hepatitis** ☐ **High Blood Pressure** ☐ **Diabetes**
    ☐ **Cancer** ☐ **Leg trauma/surgery** ☐ **Major surgeries/Hospitalizations (please list on the back)**
14. Pregnant or planning a pregnancy? ☐ YES ☐ NO How many pregnancies have you had? _____

Patient's sig:_____ Provider's sig:_____