

R e n o V e i n C l i n i c

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VEIN QUESTIONNAIRE

Date: _____

Patient Name: _____ Age: _____

PLEASE CIRCLE YOUR ANSWERS

Sex: M F

Description of veins: **unsightly** **lumpy/ropey**

Symptoms ? aching throbbing heaviness fatigue night leg cramps
 burning itching swelling edema numbness/tingling
 joint discomfort pigmentation ulcers

Which leg is affected ? right left both

Previous vein treatments: _____

Your occupation: _____

Family history of varicose veins ? yes no unknown

Details: _____

Family history of clotting problems ? yes no unknown

Details: _____

Birth control pills or hormone replacement therapy ? yes no unknown

Details: _____

Have you ever been pregnant ? yes no

How many times ? _____ Type of delivery ? _____

Miscarriages ? _____

Have you tried any kind of compression hose in the past ? yes no

Helped Did not help Refuse to wear

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