

Vein Specialty Center
2317 Gateway Drive, Suite C , Wooster, OH 44691
(330) 264-LEGS(5347)

QUESTIONNAIRE FOR PATIENT'S REGARDING VARICOSE VEINS

PATIENT'S NAME: ----- **DATE:** -----

1. Have you worn support stockings in the past? yes no
When? -----(mo/yr) How long? -----
2. Have you engaged in leg elevation as a regular part of your routine to relieve symptoms?
yes no
3. If you are overweight, have you lost weight or attempted to do so?
yes no
How much weight did you lose? -----pounds
Over what period of time? -----
4. Do you lead an active lifestyle?
yes no
Do you attempt to avoid prolonged periods of standing and sitting?
yes no
5. Do you have symptoms from your varicose veins, such as pain, aching, burning, or heaviness?
 yes no
6. Have you used non-steroidal anti-inflammatory medications (such as: ibuprofen, aspirin, or naproxen) in the past to treat the symptoms of varicose veins?
yes no
7. Do your legs swell?
yes no
If so, at what part of the day is this most noticeable? -----

