Phlebology Patient Questionnaire

Name_________________________ Date_________________ Height________ Weight______

If there is any additional information that you feel is important for us to know that is not listed below, please specify.

I. Are you seeking treatment for:
   ____ Cosmetic reasons (solely for improvement of appearance)
   ____ Medical reasons (relief of pain swelling aching or cramps)
   ____ Both

II. Vascular History-General

<table>
<thead>
<tr>
<th>Condition</th>
<th>Right Leg</th>
<th>Left Leg</th>
<th># of Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose vein problems</td>
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<tr>
<td>Phlebitis (redness and tenderness of a vein)</td>
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<tr>
<td>Blood clots</td>
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<tr>
<td>Deep Vein Thrombosis (DVT)</td>
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<tr>
<td>Leg/hip fracture or joint replacement</td>
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</tbody>
</table>

If you have ever been treated for any of these conditions, please explain:

III. Family History:

Have you or any of your family members had a blood coagulation disorder? Who?

Have you or any of your family members had any unexplained blood clots? Who?

Have you or your family members had strokes, heart attacks, blood clots, or pulmonary emboli? Who? Please explain.

Do any of your family members have varicose veins? Who?

IV. Vascular History - Specific

<table>
<thead>
<tr>
<th>Problem</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Pain in your:</td>
<td>Thigh</td>
<td>Calf</td>
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<tr>
<td>Swelling of the legs</td>
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<td>Skin or ulcer problems</td>
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<td>Pulmonary embolism</td>
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<td>Diabetes</td>
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</table>

If you experience pain in your legs: Yes No

Indicate the type of pain:

- Resting pain
- Resting cramps
- Night cramps
- Tiredness
- Heaviness in the legs
- Pain in specific areas
- Numbness
- Burning sensation

Is the pain made worse by:

- Extended periods standing
- Heat
- Menstrual periods
- Exercising and/or walking
- Medication
Is the pain improved by:  
Yes  No  
Elevation of the limbs  
Elastic stockings  
Walking and/or exercising  
Additional Comments:  

Have you ever been treated for varicose veins with:  
Sclerotherapy  Yes  No  
Laser therapy (Spider veins)  
Closure  
Surgery (vein stripping)  

V. Medications:  
Do you take or have you ever taken any of the following:  
Yes  No  Dose/Freq  
Aspirin or blood thinner (Anticoagulants)  
Pain killers (e.g. Ibuprofen)  
Arthritis medications  
Insulin  
Cortisone (steroids)  
Oral contraceptives  
(birth control pill)  
Estrogen, Progesterone or other hormones  

VI. Past History  
Have you had:  
Yes  No  Year  
Hepatitis  
Abnormal or prolonged bleeding  
Excessive bruising  
Difficult skin healing or  
Abnormal scarring  
Blood disease (e.g. Leukemia)  
Blood transfusions  
HIV infection or AIDS  
Exposure to HIV or AIDS  
Auto-immune disease (e.g. Lupus)  

VII. Personal Activities List  
Does your work require:  
Yes  No  
Prolonged standing positions  
Prolonged sitting position  
Do you wear elastic support stockings?  
Do you exercise regularly?  
In the course of a normal day how much time is spent in  
standing position (Circle one)?  
10 - 25% of the day  
25 - 50% of the DAY  
More than 50%  
Do you smoke?  
If yes, how many per day? ___________________________  
How many years? ___________________________  
What do/did you smoke? ___________________________  

Name (please print) ___________________________ Date __________________