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

Do you have or have you ever had:	Right Leg	Left Leg	# of Years	
Varicose vein problems				
Phlebitis (redness and tenderness of a vein)				
Blood clots				
Deep Vein Thrombosis (DVT)				
Leg/hip fracture or joint replacement				
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

Indicate which of these problems you have had:	
Pain in your:	
Thigh	
Calf	
Entire Leg	
Swelling of the legs	
Skin or ulcer problems	
Pulmonary embolism	
Diabetes	

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: Aspirin or blood thinner(Anticoagulants)	Yes	No	Dose/Freq	
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_____