# Surgical Services, PC

## Patient Questionnaire

Name: _____ Date: _____

Occupation: _____ Birthdate: _____

Have you had any vein procedures in the past? ❑ Yes ❑ No

If yes, please list: _____

What were the date(s) of treatment? _____

**Do you now have any of following?**

| | | |
|---|---|---|
| Aching/Pain | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Heaviness | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Itching/burning | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Swelling | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Cramping | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Throbbing | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Ulcers | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Discoloration | ❑ Yes ❑ No | Leg (Circle): Right / Left |
| Spider Veins | ❑ Yes ❑ No | Leg (Circle): Right / Left |

**Do you use any of the following conservative measures?**

| | | |
|---|---|---|
| Medication | ❑ Yes ❑ No | List: _____ |
| Elevation | ❑ Yes ❑ No | How often: _____ |
| Compression hose? | ❑ Yes ❑ No | If so, what compression? _____ |
| | | Length of time worn? _____ |
| Do you exercise regularly? | ❑ Yes ❑ No | If so, what/how often? _____ |

**List any other concerns/questions about your spider or varicose veins:**

_____

_____

_____

Patient Signature: _____ Date: _____