



## UAB Vein Clinic - Patient Questionnaire

**Please take a moment to consider the following questions. If you answer yes, when indicated, please rate how important the response is to your quality of life and activities of daily living.**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**How did you hear about us?** (Please indicate by circling the letter for the appropriate response)

- A. Physician referral; name of physician: \_\_\_\_\_
- B. Word of mouth
- C. Insurance company: \_\_\_\_\_
- D. Other: \_\_\_\_\_

<b>Do you have:</b>	<b>No</b>	<b>Yes</b>	<b>Less Important</b>		<b>to</b>	<b>Very Important</b>	
Pain/aching/throbbing?	N	Y	1	2	3	4	5
Night Cramps?	N	Y	1	2	3	4	5
Leg tiredness?	N	Y	1	2	3	4	5
Itching of the skin near or a vein?	N	Y	1	2	3	4	5
Swelling of feet/ankles?	N	Y	1	2	3	4	5
Skin discoloration?	N	Y	1	2	3	4	5
Skin rash or eczema?	N	Y	1	2	3	4	5
Sores or ulcers on legs/ankles?	N	Y	1	2	3	4	5
Unightly appearance of your veins?	N	Y	1	2	3	4	5

**If you have pain, please circle most appropriate:**

none    occasional    interferes with daily activity    limits daily activity

**Do you use over-the-counter pain medication for leg discomfort?**

No    Yes (If yes, specify type of medication \_\_\_\_\_)

**If you have swelling, please circle most appropriate:** none    foot/ankle    below knee    above knee

**Do you use compression stockings?**

No    Yes (If yes, specify type of stocking \_\_\_\_\_ duration of use \_\_\_\_\_ )  
 (circle most appropriate: none    intermittent    most days    fully comply )

**What makes the symptoms better?**

Rest    Elevation    Stockings    Massaging    Walking    Changing positions

**What makes the symptoms worse?**

Standing    Menstrual cycle    Walking/exercise    Prolonged sitting

**Did you notice a change in your veins following? (Circle)**

Leg injury    Pregnancy    Medication    Surgery    Blood clot in leg

**Describe the veins in your legs (circle)**

Rope-like    spider veins    blue lines    knots

**Have you ever had any of the following problems related to your leg veins?**

Clot in leg vein (DVT)?	N	Y	Inflammation of vein ("Phlebitis")?	N	Y
Clot in your lung (Pulmonary Embolus)?	N	Y	Venous related ulcers?	N	Y
Spontaneous rupture of vein?	N	Y			

**Do you have a family history of (circle):**

- a. Varicose vein problems
- b. Phlebitis (inflammation of a vein)
- c. Blood clots (DVT or Pulmonary Embolus)
- d. Leg ulcer

**Have you ever had any of the following medical problems?**

Clotting disorder?	N	Y	Asthma?	N	Y
Need for blood thinner medication	N	Y	Stroke?	N	Y
Leg trauma?	N	Y	Heart problems?	N	Y
Obesity?	N	Y	Aneurysm?	N	Y
Malignancy?	N	Y	Artery disease legs?	N	Y
Major trauma?	N	Y	Tobacco use?	N	Y
Prolonged immobility (any reason)?	N	Y	Diabetes?	N	Y
Easy bruising?	N	Y	Seizures?	N	Y
Thrombocytopenia?	N	Y	Fainting / dizziness?	N	Y
High blood pressure?	N	Y	Hives?	N	Y
Autoimmune diseases?	N	Y	Hepatitis?	N	Y

**Do you work?** No Yes (If yes, specify type of work \_\_\_\_\_ )

**Does your work require:**

- a. Prolonged standing position N Y
- b. Prolonged sitting position N Y

**In the course of a normal day, how much time is spent in a standing position during the day?**

- a. 10% of the day
- b. 20% to 30%
- c. 30% to 50%
- d. More than 50%

**Due to the symptoms above; are you limited in any of the following activities?**

	No	Yes	Fewer	Limitations	to	Very Limited
Work?	N	Y	1	2	3	4 5
Housework routines?	N	Y	1	2	3	4 5
Walking?	N	Y	1	2	3	4 5
Shopping?	N	Y	1	2	3	4 5
Sports or hobbies?	N	Y	1	2	3	4 5
Social Limitations?	N	Y	1	2	3	4 5

**Due to social embarrassment, do you limit any of the following activities?**

	No	Yes	Fewer	Limitations	to	Very Limited
Sport?	N	Y	1	2	3	4 5
Exercise?	N	Y	1	2	3	4 5
Leisure Activities?	N	Y	1	2	3	4 5
Job Choices?	N	Y	1	2	3	4 5
Do you limit your clothing choices?	N	Y	1	2	3	4 5

**Have you had vein evaluations in the past elsewhere?**

No Yes (If yes, where? \_\_\_\_\_ when? \_\_\_\_\_ )

**Have you had prior procedures or operations on the veins of your legs?**

No Yes  
(If yes, where? \_\_\_\_\_ when? \_\_\_\_\_ what? \_\_\_\_\_ )

**What are your expectations for today's visit?**

- A. Evaluate leg pain and/or swelling
- B. To learn more about my vein problem
- C. To learn about surgical options for varicose veins.
- D. To learn about cosmetic options for spider veins.
- E. Other \_\_\_\_\_

**Do you have any other concerns about your veins that need to be addressed during your visit today?**

\_\_\_\_\_