UT★Physicians
A Part of UTHealth

PATIENT NAME:

SHEILA COOGAN, MD, FACS

Vascular Surgeon

Please complete the following questionnaire, trying not to leave any blank spaces. The more information we have, the better we can care for you.

VARICOSE VEINS / SPIDER VEINS QUESTIONAIRE

How old were you when you first noticed your varicose veins? _____________
Have your veins gotten worse in recent months? __________
Do you stand for long hours at home/work? ___________
Which of the following do you do to treat your leg symptoms?

Medication	No ______	Yes _____	Name:
Elevation of the legs	No ______	Yes _____	
Wear support hose/ stocking	No ______	Yes _____	For how long? ____________

Do you have or have you ever been diagnosed with any of the following? (**You <u>MUST</u> select a number for each line**)

Aching	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Tiredness / fatigue	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Burning	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Restless legs	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Vein swelling	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Phlebitis (redness, tenderness of vein)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Skin discoloration / changes	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Pain (sharp / stabbing)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Ankle swelling, leg swelling	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Throbbing	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Blood clots (DVT)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Heaviness	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Itching	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Night cramps	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Vein bleedings that difficult to control	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Open wounds / ulcer	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Spider veins	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5

Vein Treatment History: Have you ever been treated for varicose veins with the following?

Sclerotherapy (vein injection)	No__	Yes__	R______	L_______	Year? ____________
Vein stripping	No__	Yes__	R______	L_______	Year? ____________
Phlebectomy	No__	Yes__	R______	L_______	Year? ____________
Vein stripping	No__	Yes__	R______	L_______	Year? ____________
Vein ablation procedure	No__	Yes__	R______	L_______	Year? ____________

Family History: Do any of your family members have the following?

Varicose veins	No ____	Yes ____	Who? _____________
Vein stripping	No ____	Yes ____	_____________
Blood clots/ pulmonary embolism	No ____	Yes ____	_____________
Blood coagulation disorder	No ____	Yes ____	_____________
Heart disease/ heart attack	No ____	Yes ____	_____________

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Have you tried exercise to alleviate symptoms? If yes, what type? ____

____

Are your symptoms affecting your daily life? If yes, how? ____

What makes your legs feel better? ____

____

What makes your legs feel worse? ____

____