

VEIN THERAPY

Patient Questionnaire/Evaluation

Date ___/___/20___

Name _____ Birth Date _____ Age _____

Sex _____ Height _____ Weight _____

1. How many years have you been aware of this problem? _____
2. Have you ever been previously treated for this problem?

Yes ___ No ___

By whom and when? _____

With what method?

Injection _____ Laser _____

Surgery _____

Electrocautery _____ Surgery _____

When did the problem with your veins occur?

Approximate Age _____

Before Pregnancy _____ After Pregnancy _____

After trauma or Premarin therapy _____

Other _____

3. Is there a history of varicose or spider veins?
Mother ___ Father ___ Sister ___ Brother ___ Children ___
Aunts ___ Uncles ___
5. Do you have a history of : Smoking ___ Blood Clots ___ Lupus ___
Bleeding disorders ___ Easy bruising ___ Easy scarring ___
Dark spots after skin injury or surgery _____
6. Are you developing new veins? _____
7. Are your present veins getting bigger? _____
8. After prolonged standing or sitting do your legs ache? _____
9. Do your legs or veins ache before menses? _____
10. Does walking or exercise relieve or aggravate the pain? (Please circle)
11. Describe any symptoms you have from your veins: _____

12. Are you required to be on your feet for long periods? _____
13. Do you JOG RUN JUMP ROPE AEROBICS? (Please circle)
14. Are you pregnant or planning a pregnancy soon? _____
15. Did you read and understand the patient education materials given to you? _____
16. Do you understand the risks and benefits as well as possible complications to vein injection? _____
17. Is your problem cosmetic or medical? _____
18. Are you prepared to wear hose on a regular basis as described? _____

