Triangle Vein Clinic

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TVC Questionnaire (page 1 of 1)

PATIENT NAME _____ ACCOUNT # _____

Please fill out this form completely.

1. How long have you had varicose veins? _____ years.
2. How long have you had spider veins? _____ years.
3. Are you seeking treatment for cosmetic purposes only? ☐ Yes ☐ No
4. Do you suffer from (check all that apply):

☐ Leg pain	☐ Leg aching	☐ Traumatic bleeding
☐ Tired/heavy legs	☐ Throbbing	☐ Leg ulcers
☐ Leg cramps	☐ Burning/stinging	☐ Other_____
☐ Leg swelling	☐ Skin color changes	☐ Other_____
☐ Leg itching	☐ Blood clots	☐ Other_____

5. If so, how long have you experienced symptoms in your lower extremities? _____ years.
6. Are your symptoms worse with prolonged standing? ☐ Yes ☐ No
7. Are your symptoms worse at the end of the day? ☐ Yes ☐ No
8. Are your symptoms worse with menses? ☐ Yes ☐ No
9. Do you have a family history of varicose veins/spider veins? If yes, who? _____

_____

10. Do you believe your varicosities are related to pregnancy? ☐ Yes ☐ No
11. Do you believe your varicosities are related to injury or trauma? ☐ Yes ☐ No
12. Have you ever:
    a. Elevated your legs for relief? ☐ Yes ☐ No
    b. Used over-the-counter medications such as Advil, Motrin, Tylenol,or Aleve to relieve your discomfort? ☐ Yes ☐ No
    c. Worn support hose for relief? ☐ Yes ☐ No
    d. If yes, did they help your symptoms? ☐ Yes ☐ No
    e. Worn prescription graduated compression stockings? ☐ Yes ☐ No
    If yes, for how long? _____
    Did they relieve your symptoms? ☐ Yes ☐ No
13. Have you ever seen another physician for this problem? ☐ Yes ☐ No
14. If yes, did you receive treatment? ☐ Yes ☐ No
15. If yes, what kind of treatment and when? _____

_____

PATIENT SIGNATURE _____ DATE _____

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