CharlotteRadiology™

Vein Centers

Venous Patient Questionnaire

Patient Name: _____ DOB: _____

PLEASE INDICATE WHICH LEG IS SYMPTOMATIC: ☐ LEFT ☐ RIGHT ☐BOTH

SYMPTOMOLOGY

Please mark yes or no to each:

YES	NO	
☐	☐	Varicose veins (visibly enlarged, bulging veins beneath the skin)
☐	☐	Spider veins (small, visible blood vessels in the skin which take on a blue or red color)
☐	☐	How long have you had this problem? _____
☐	☐	Tiredness in legs?
☐	☐	Pain and aching. How long? _____
☐	☐	Swelling
☐	☐	Night cramps
☐	☐	Skin changes/ulcers
☐	☐	Are symptoms worse at any specific time of day? When? _____
☐	☐	Are symptoms worse with any certain activities? What? _____
☐	☐	Have you tried support stockings? How long? _____
☐	☐	Have you had any prior vein treatments? Describe: _____
		Other symptoms: _____

MEDICAL HISTORY

YES	NO	
☐	☐	Have you had a previous blood clot? When? _____
☐	☐	Is it possible you are pregnant?
		If you have been pregnant in the past, # of pregnancies _____ # of children _____
☐	☐	Do you have asthma?
☐	☐	Are you currently on any birth control medication or hormones?
☐	☐	Do you smoke?
☐	☐	Do you drink alcohol?

List current medical conditions: _____

List all current medications: _____

List all allergies (medicine, tape, latex, etc.): _____

Height: _____ Weight: _____

PAST SURGERIES

YES	NO	
☐	☐	Leg bypass surgery? Which leg? _____ When? _____
☐	☐	Heart bypass surgery? When? _____
☐	☐	Knee/hip surgery? (replacement)
☐	☐	Other surgeries? _____

FAMILY HISTORY (Mark those that apply to any family member)

YES	NO	
☐	☐	Blood clots or phlebitis
☐	☐	Varicose or spider veins
☐	☐	Vascular or bypass surgery
☐	☐	Bleeding problems
☐	☐	Diabetes

Patient signature _____ Date _____