UAB MEDICINE
VEIN CLINIC
Knowledge that will change your world

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: _____

DOES your leg have:

Pain	none	a little	some	a good bit	most of the time	all the time
Aching	none	a little	some	a good bit	most of the time	all the time
Throbbing	none	a little	some	a good bit	most of the time	all the time
Heaviness	none	a little	some	a good bit	most of the time	all the time
Night cramps	none	a little	some	a good bit	most of the time	all the time
Leg Tiredness	none	a little	some	a good bit	most of the time	all the time
Leg Swelling	none	a little	some	a good bit	most of the time	all the time
Skin Discoloration	none	a little	some	a good bit	most of the time	all the time
Skin Rash	none	a little	some	a good bit	most of the time	all the time
Ulcers/ Sores	none	a little	some	a good bit	most of the time	all the time
Itching	none	a little	some	a good bit	most of the time	all the time
Appearance	none	a little	some	a good bit	most of the time	all the time

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 evening only afternoon morning

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
Need for blood thinner medication	N	Y
Leg trauma?	N	Y
Obesity?	N	Y
Major trauma?	N	Y
Prolonged immobility (any reason)?	N	Y
Thrombocytopenia?	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?

Work	none	a little	some	a good bit	most of the time	all the time
Housework	none	a little	some	a good bit	most of the time	all the time
Walking	none	a little	some	a good bit	most of the time	all the time
Shopping	none	a little	some	a good bit	most of the time	all the time
Sports or Hobbies	none	a little	some	a good bit	most of the time	all the time
Social limitations	none	a little	some	a good bit	most of the time	all the time

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

Sport	none	a little	some	a good bit	most of the time	all the time
Exercise	none	a little	some	a good bit	most of the time	all the time
Leisure Activities	none	a little	some	a good bit	most of the time	all the time
Job choices	none	a little	some	a good bit	most of the time	all the time
Clothing choices	none	a little	some	a good bit	most of the time	all the time

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?
