UAB VEIN CLINIC PATIENT QUESTIONNAIRE

Name _____ **Date of Birth** _____ **Date** _____

How did you hear about us? (Please indicate by checking the box for the appropriate response.)

☐ Physician referral (include physician name): _____

☐ Other: _____

Review of Systems: (Circle)

Fever	Vision changes/disturbances	Reduced hearing	Shortness of breath	Chest pain
Chills	Yellowing of the white of the eyes	Ear pain	Cough	Palpitations
Sweats	Drainage	Nasal congestion	Phlegm production	Skipped beats
Weakness	Blurry vision	Sore throat	Coughing up blood	Fast irregular beats
Fatigue/tired	Double vision	Difficulty swallowing	Wheezing	Swollen feet/legs
Weight loss	Other:_____	Dizziness	Other: _____	Fainting/dizziness
Weight gain		Other: _____		Passing out
Other: _____				Other: _____

Nausea	Painful urination	Easy Bruising	Excessive thirst	Immunocompromised
Vomiting	Blood in urine	Excessive bleeding	Excessive urination	Recurrent fever
Diarrhea	Change in urine habits	Swollen lymph nodes	Cold intolerance	Recurrent infection
Constipation	Frequent urination	Other: _____	Heat intolerance	Other: _____
Heartburn	Pus/drainage/discharge		Hot flashes	
Abdominal pain	Sores		Abnormal/missed periods	
Bloody vomit	Sexual difficulties		Other: _____	
Bloody stool	Other: _____			
Other: _____				

Back pain	Rash	Forgetfulness/confusion	Anxiety
Neck pain	Itching/dryness	Numbness	Depression
Joint pain	Breakdown	Tingling	Hallucinations
Muscle pain	Red bumps/spots	Headaches	Other: _____
Difficulty walking	Open sores	Abnormal balance	
Decreased movement of joints	Acne	Falls	
Other: _____	Breast pain or discharge	Muscle weakness	
	Other: _____	Other: _____	

Family History (including aunts and uncles). Please check if "Yes"; not checking a box is considered a "No" answer.

Has any blood relative ever had?	Relationship to you?
☐ Seizure disorder	_____
☐ Mental illness	_____
☐ Cancer	_____
☐ Bleeding disorders	_____
☐ Diabetes	_____
☐ Blood clotting	_____
☐ Heart trouble	_____
☐ Kidney trouble	_____
☐ High blood pressure	_____
☐ Alzheimer's disease	_____
☐ Stroke	_____
☐ Aneurysm	_____

List any operations/procedures you have had:

Operation	Date	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your RIGHT leg have: (Circle)

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

Does your LEFT leg have: (Circle)

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

Do you use over-the-counter pain medication for leg discomfort?

☐ No ☐ Yes (If yes, specify type of medication.) _____

If you have swelling, when: ☐ None ☐ Evening only ☐ Afternoon ☐ Morning

Do you use compression stockings?

☐ No ☐ Yes (If yes, specify type of stocking.) _____ Duration of use _____

(Check most appropriate): ☐ None ☐ Intermittent ☐ Most days ☐ Full Compliance

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?

☐ Leg injury ☐ Pregnancy (How many?) _____ ☐ Medication ☐ Surgery ☐ Blood clot in leg

Describe the veins in your legs (check all that apply):

Right Leg: ☐ Blue lines ☐ Knots ☐ Rope-like ☐ Spider veins ☐ Varicose veins

Left Leg: ☐ Blue lines ☐ Knots ☐ Rope-like ☐ Spider veins ☐ Varicose veins

Have you ever had any of the following problems related to your leg veins?

Clot in leg vein (DVT)	☐ No	☐ Yes	Inflammation of vein (phlebitis)	☐ No	☐ Yes
Clot in your lung (pulmonary embolus)	☐ No	☐ Yes	Venous-related ulcers	☐ No	☐ Yes
Spontaneous rupture of vein	☐ No	☐ Yes			

Do you have a family history of?

☐ Varicose vein problems

☐ Phlebitis (inflammation of a vein)

☐ Blood clots (DVT or pulmonary embolus)

☐ Leg ulcer

Have you ever had any of the following medical problems?

Clotting disorder	☐ No	☐ Yes
Need for blood thinner medication	☐ No	☐ Yes
Leg trauma	☐ No	☐ Yes
Obesity	☐ No	☐ Yes
Major trauma	☐ No	☐ Yes
Prolonged immobility (for any reason)	☐ No	☐ Yes
Thrombocytopenia	☐ No	☐ Yes

Do you work? ☐ No ☐ Yes (If yes, specify type of work) _____

Does your work require?

Prolonged standing position ☐ No ☐ Yes

Prolonged sitting position ☐ No ☐ Yes

In the course of a normal day, how much time is spent in a standing position during the day?

☐ 10% of the day ☐ 30-50%

☐ 20-30% ☐ More than 50%

How have these symptoms affected your work/activities:

a. None

b. Symptoms are there, but full work/activities

c. Mildly reduced work/activities

d. Moderately reduced work/activities

e. Severely reduced work/activities

f. Unable to work

Have you had vein evaluations elsewhere in the past?

☐ 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?

☐ Evaluate leg pain and/or swelling

☐ To learn more about my vein problem

☐ To learn about surgical options for varicose veins

☐ To learn about cosmetic options for spider veins

☐ Other: _____

Do you have any other concerns about your veins that need to be addressed during your visit today?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____