Venous Insufficiency Patient Questionnaire

Veinology Health – Patient Symptom & History Form

Patient Name: _____
Date of Birth: _____
Date: _____

Section 1: Symptoms

Please circle all that apply:

- Leg pain or aching
- Heaviness or fatigue in legs
- Swelling of ankles/legs
- Varicose veins (bulging veins)
- Spider veins (small surface veins)
- Skin changes (darkening, thickening, redness)
- Itching or burning in legs
- Restless legs
- Nighttime leg cramps
- Leg ulcers or wounds that are slow to heal
- Other: _____

Section 2: Symptom Details

Which leg is affected?

- Right
- Left
- Both

When are your symptoms worse (circle all that apply)?

- At the end of the day
- After standing for long periods
- After sitting for long periods
- During the night
- Other: _____

How long have you had these symptoms?

- Less than 6 months
- 6 months – 1 year
- 1–5 years
- More than 5 years

Section 3: Medical & Lifestyle History

What activities of daily living do these symptoms impact (circle all that apply):

- Walking ability
- Standing for extended periods
- Running ability
- Ability to Exercise
- House hold chores
- Working/have you missed any work
- Playing with your children
- Sleep disturbances
- Self care and daily grooming
- Shopping
- Driving/traveling

Do you have a family history of varicose veins or venous disease?

- Yes- If yes, who? _____
- No
- Unknown

Section 4: Lifestyle & Risk Factors

- Occupation involves mostly (circle all that apply):
  - Sitting
  - Standing
  - Walking/movement
- Do you exercise regularly?
  - Yes
  - No
- Number of pregnancies (if applicable): _____
- Do you smoke?
  - Yes
  - No

Section 5: Symptom Severity (0–10 Scale)

Please rate how severe your leg symptoms are on average:

Right leg: 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ (worst possible)

Left leg: 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □

Section 6: Additional Information

Please describe any other concerns or symptoms: