KALLAL MEDICAL GROUP

VEIN TREATMENT QUESTIONNAIRE

Patient Name _____ Date of Birth _____ Today's Date _____

VASCULAR HISTORY

Do you have or have you ever been diagnosed with:

Varicose vein problems	○ Yes	○ No	Leg: ☐ Right ☐ Left
Phlebitis (vein redness / tenderness)	○ Yes	○ No	Leg: ☐ Right ☐ Left
Blood clots	○ Yes	○ No	Leg: ☐ Right ☐ Left
Deep vein thrombosis (DVT)	○ Yes	○ No	Leg: ☐ Right ☐ Left
Saphenous vein reflux	○ Yes	○ No	Leg: ☐ Right ☐ Left

Do you experience any of the following in your leg(s):

Aching / pain	○ Yes	○ No	Leg: ☐ Right ☐ Left
Heaviness	○ Yes	○ No	Leg: ☐ Right ☐ Left
Tiredness / fatigue	○ Yes	○ No	Leg: ☐ Right ☐ Left
Itching / burning	○ Yes	○ No	Leg: ☐ Right ☐ Left
Swelling	○ Yes	○ No	Leg: ☐ Right ☐ Left
Cramps	○ Yes	○ No	Leg: ☐ Right ☐ Left
Restless legs	○ Yes	○ No	Leg: ☐ Right ☐ Left
Throbbing	○ Yes	○ No	Leg: ☐ Right ☐ Left
Skin or ulcer problems	○ Yes	○ No	Leg: ☐ Right ☐ Left
Other: _____			Leg: ☐ Right ☐ Left

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	○ Yes ○ No	What: _____
Elevation of legs	○ Yes ○ No	
Wear support hose	○ Yes ○ No	How long? _____Months

FAMILY HISTORY

Have any of your family members had:

Varicose veins	○ Yes ○ No	Relationship: _____
Vein stripping	○ Yes ○ No	Relationship: _____
Blood coagulation disorder	○ Yes ○ No	Relationship: _____
Blood clots	○ Yes ○ No	Relationship: _____
Stroke	○ Yes ○ No	Relationship: _____
Heart attack	○ Yes ○ No	Relationship: _____
Pulmonary embolism	○ Yes ○ No	Relationship: _____

VEIN TREATMENT HISTORY

Have you ever been treated for varicose veins with:

Sclerotherapy	○ Yes ○ No	Leg: ☐ Right ☐ Left
Laser therapy (spider veins)	○ Yes ○ No	Leg: ☐ Right ☐ Left
Phlebectomy	○ Yes ○ No	Leg: ☐ Right ☐ Left
Vein stripping surgery	○ Yes ○ No	Leg: ☐ Right ☐ Left
RF ablation (VNUS Closure®)	○ Yes ○ No	Leg: ☐ Right ☐ Left

PERSONAL ACTIVITIES LIST

Does your work require:

Prolonged standing periods	○ Yes ○ No
Prolonged sitting periods	○ Yes ○ No

LIFESTYLE

Do you exercise regularly? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Pregnancies ○ Yes ○ No How many: _____

UPLOAD **Upload completed form to Kallal Medical Group via secure website form.**