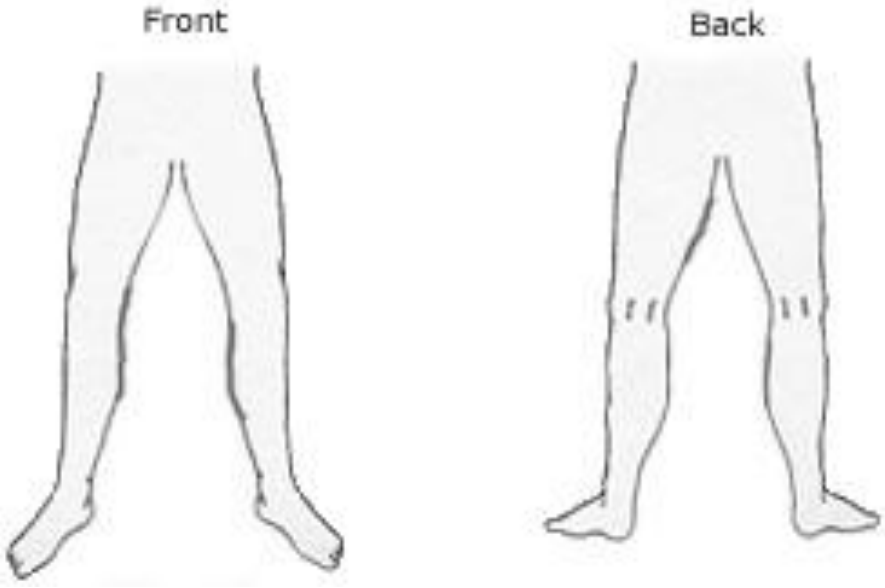
Bayside Vein & Laser Center, PLLC

Patient Name_____ Date_____

Vein Questionnaire



Please draw location of your veins

Please check all symptoms that you have

Symptoms	***None***	***Mild*** Occasional	***Moderate*** Several Times per week	***Severe*** Daily
Sharp/Stinging Pain	☐0	☐1	☐2	☐3
Dull/Aching Pain	☐0	☐1	☐2	☐3
Burning	☐0	☐1	☐2	☐3
Heaviness	☐0	☐1	☐2	☐3
Swelling	☐0	☐1	☐2	☐3
Itching	☐0	☐1	☐2	☐3

History	***Never***	***Once***	***2 or more times***
Phlebitis (inflammation)	☐0	☐2	☐3
Ruptured Vein/ Bleeding	☐0	☐2	☐3
Ulcers (open sores)	☐0	☐2	☐3
DVT (blood clots)	☐0	☐2	☐3

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Please check all that apply:

☐ **I use pain meds (prescription or over-the counter) for my discomfort caused by my veins.** IF SO, List Type, Frequency, and Amount_____

☐ **I use compression stockings**
If so what strength, how often, and how long have you used?
_____

☐ **I need to elevate my legs throughout the day.** IF SO, How Often_____

☐ **My discomfort is worse when sitting or standing for long periods of time.** If SO, Is This A Requirement Of Your Job Or Home Life?_____
AND What Is Your Job Title_____

Please check all that apply

The discomfort and swelling of my veins interferes with:

☐ My Job	☐ Exercise	☐ Cooking
☐ Yard Work	☐ Housework	☐ Travel
☐ Family Life	☐ School	☐ Sex Life
☐ Other Activities_____		

If you checked answers above, please explain to what extent this affects your lifestyle and what your limitations are:

_____

_____

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