UT Physicians
A Part of UTHealth

PATIENT NAME:

SHEILA COOGAN, MD, FACS

Vascular Surgeon

Please complete the following questionnaire, trying not to leave any blank spaces. The more information we have, the better we can care for you.

VARICOSE VEINS / SPIDER VEINS QUESTIONAIRE

How old were you when you first noticed your varicose veins? _____
Have your veins gotten worse in recent months? _____
Do you stand for long hours at home/work? _____
Which of the following do you do to treat your leg symptoms?

Medication	No _____	Yes _____	Name:
Elevation of the legs	No _____	Yes _____	
Wear support hose/ stocking	No _____	Yes _____	For how long? _____

Do you have or have you ever been diagnosed with any of the following? (**You MUST select a number for each line**)

Aching	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Tiredness / fatigue	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Burning	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Restless legs	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Vein swelling	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Phlebitis (redness, tenderness of vein)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Skin discoloration / changes	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Pain (sharp / stabbing)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Ankle swelling, leg swelling	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Throbbing	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Blood clots (DVT)	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Heaviness	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Itching	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Night cramps	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Vein bleedings that difficult to control	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Open wounds / ulcer	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5
Spider veins	**Right** 1 2 3 4 5	**Left** 1 2 3 4 5

Vein Treatment History: Have you ever been treated for varicose veins with the following?

Sclerotherapy (vein injection)	No__ Yes__	R_____	L_____	Year? _____
Vein stripping	No__ Yes__	R_____	L_____	Year? _____
Phlebectomy	No__ Yes__	R_____	L_____	Year? _____
Vein stripping	No__ Yes__	R_____	L_____	Year? _____
Vein ablation procedure	No__ Yes__	R_____	L_____	Year? _____

Family History: Do any of your family members have the following?

Varicose veins	No ____	Yes ____	Who? _____
Vein stripping	No ____	Yes ____	_____
Blood clots/ pulmonary embolism	No ____	Yes ____	_____
Blood coagulation disorder	No ____	Yes ____	_____
Heart disease/ heart attack	No ____	Yes ____	_____

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Have you tried exercise to alleviate symptoms? If yes, what type? _____

_____

Are your symptoms affecting your daily life? If yes, how? _____

What makes your legs feel better? _____

_____

What makes your legs feel worse? _____

_____