

Patient Name: _____

What is the main reason for your visit today? _____

How long have you had this problem? _____ Years _____ Months

Please check which symptoms you have:

- | | | | |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Tired/Heavy Legs | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Aching/Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Open Sore/Ulcer | <input type="checkbox"/> Red Warm Areas | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Other: _____ | | | |

On a scale from 0 (none) to 10 (severe), how would you rate your symptoms? _____

Have your symptoms/veins gotten worse in recent months? No Yes

Are your symptoms worse with? Prolonged sitting/standing Menstrual Cycle Hot Baths

Are your symptoms improved by? Rest and Elevation Walking Support hose Pain medication

How do your symptoms alter your daily activities at work/home? _____

How do your symptoms alter your leisure activities (such as sports, hobbies, social life, and family)? _____

Do you exercise regularly? No Yes

Describe activity: _____

Have you ever worn **prescription** compression stockings? No Yes If yes; for how long? _____

Date first worn? _____ First prescribed by? _____

Pressure: < 20 mmHg 20-30 mmHg 30-40 mmHg

Type: Knee-hi Thigh-high Pantyhose

Any improvement of symptoms with stockings? No Yes

Have you taken any medications (prescription/ over the counter) for your symptoms? No Yes

If yes: Name and strength _____ How many times per day? _____

Any improvement of symptoms with medications? No Yes

Have you ever had treatment for veins? No Yes if yes, explain: _____

Physician Signature: _____ Date: _____