

J. THOMAS CRITCHLOW, M.D.
VEIN QUESTIONNAIRE

Name _____ Date _____

Age _____ Height _____ Weight _____

Referred by _____

1. How many years have you noticed this problem? _____

2. Have you ever been previously treated? _____

If so, when and where? _____

Injections? _____

Cautery? _____

Laser? _____

Surgery? _____

Worn Stockings? _____

Medication? (i.e., Motrin, Ibuprofen, etc.) _____

Tried to Lose Weight? _____

Leg Elevation? _____

Exercise? _____

3. When did you first notice the veins?

Age _____

Before/During/After Pregnancy _____

4. Is there a family history of varicose/spider veins? _____

5. Any personal history of:

Thrombophlebitis? _____

Pulmonary Embolism? _____

Blood Clots? _____

Lupus? _____

Bleeding Disorders? _____

Leg Ulcers? _____

Cancer? _____

6. Do you stand/sit for long periods of time? _____

7. Are you presently pregnant or planning a pregnancy soon? _____