

8. Are you currently taking any medication for your veins? \_\_\_\_\_

9. Do your veins/legs:

	Right Leg	Left Leg
Ache/Pain?	_____	_____
Swell?	_____	_____
Itch/Burn/Stinging	_____	_____
Cause Cramping?	_____	_____
Become Red?	_____	_____
Feel Heavy?	_____	_____
Throb?	_____	_____
Feel Tired/Fatigued?	_____	_____
Have discoloration?	_____	_____
Have a change in skin texture?	_____	_____

10. Does the appearance of the veins bother you? \_\_\_\_\_

11. Do you have a feeling of unpleasant sensations of one sort or another (creeping, tingling, aching) in the legs when sitting or lying down? \_\_\_\_\_

Does this cause a strong urge to move the legs and does such movement (usually walking) temporarily relieve the discomfort? \_\_\_\_\_

If yes...

- Do these feelings occur during the day? \_\_\_\_\_
- Do these feelings occur during the night? \_\_\_\_\_
- Does your bed partner complain of you having frequent leg movement? \_\_\_\_\_
- Does anyone else in your family have similar symptoms? \_\_\_\_\_
- How long have you had these symptoms? \_\_\_\_\_
- Do you currently have these symptoms? \_\_\_\_\_

### AUTHORIZATIONS

I hereby authorize Dr. Critchlow to furnish information to insurance carriers and referred physicians concerning my illness and treatment.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I hereby authorize my insurance benefits to be paid directly to J. Thomas Critchlow, M.D. I understand I am financially responsible for all charges.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)