Somerset Surgical Associates

Physician/Nurse Varicose Vein Questionnaire

Name: _____ Date: _____

Which leg is affected? Left / Right / Both

Do you have any of the following?

- Pain : Yes / No
- Heaviness/achiness : Yes / No
- Swelling : Yes / No
- Burning : Yes / No
- Discoloration : Yes / No
- Lower extremity wound : Yes / No
- History of DVT (deep vein thrombosis) Yes / No **or** superficial vein thrombosis: Yes / No

Do the above interfere with your daily activities? Yes No. If yes, explain:

_____

Have you had prior vein surgery? Yes / No

If yes, please explain: _____

Do you take Motrin, Advil, Tylenol, and/or aspirin for vein discomfort? Yes / No.

If yes, for how long or how often? _____

Do you elevate your legs when resting? Yes / No

Have you ever worn support stockings, ace bandage, or compression stockings for longer than 3 months? Yes / No

Did you ever have sleep disturbances accompanied by leg restlessness? Yes / No

Nurse's/MD Signature: _____ Date: _____

Gunaseelan Ambrose, MD, FACS ● Obi J Imegwu, MD, FACS
Thangamani Seenivasan, MD, FACS ● William M. Sugarmann, MD, FACS
30 Rehill Avenue, Suite 3400, Somerville, NJ 08876
(P) 908-725-2400 (F) 908-927-8990
www.somersetsurgicalassociates.com
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