Northern Illinois Vein Clinic

Examination Questionnaire

Patient Last Name_____Patient First Name_____Date____/____/____

Date of Birth: ____/____/____ Age: _____ Sex: M / F

Primary Physician: _____

General Medical History

List past and present medical illnesses and year diagnosed:_____

_____

_____

List any surgeries and year performed:_____

_____

_____

Please list any allergies you may have: _____

Are you allergic to: Latex YES NO _____Reaction
Iodine YES NO _____Reaction
Adhesive YES NO _____Reaction
Lidocaine YES NO _____Reaction

Please list all prescription and non prescription medications. Include dose and how often you take the Medication: _____

_____

_____

List any health issues you are having unrelated to your legs:_____

_____

Vein History

What is the reason why you are seeking treatment? Cosmetic Medical

Have you seen any other doctors for treatment of your veins? Yes No

If yes, please explain: _____

Do you or have you ever worn compression stockings? Yes No

If yes, when and for how long_____ Do/did they help? Yes No

Have you ever had a blood clot in your legs? Yes No

If yes, please detail when and in which leg: _____

Please continue on next page

Do you experience any of the following symptoms in your legs?

Aching/Pain	No	Yes	**Rt**	how long___	**Lt**	how long___
Heaviness	No	Yes	**Rt**	how long___	**Lt**	how long___
Tiredness/Fatigue	No	Yes	**Rt**	how long___	**Lt**	how long___
Itching/Burning	No	Yes	**Rt**	how long___	**Lt**	how long___
Swollen Ankles	No	Yes	**Rt**	how long___	**Lt**	how long___
Leg Cramps	No	Yes	**Rt**	how long___	**Lt**	how long___
Throbbing	No	Yes	**Rt**	how long___	**Lt**	how long___
Restless Legs	No	Yes	**Rt**	how long___	**Lt**	how long___

Any other leg symptoms? _____

Do you have problems walking? Yes No

If yes, please explain: _____

Are your symptoms worse at the end of the day? Yes No

Are the problems you are having in your legs interfering with your lifestyle? Yes No

If yes, please explain:_____

BELOW TO BE COMPLETED BY OFFICE STAFF

Physical Findings

Blood Pressure_____

Pulse_____

Respirations_____

Lung sounds_____

Heart sounds_____

Leg measurements

Right leg	**Left leg**	Date_____
Ankle_____	Ankle_____	Stockings Given ☐
Calf_____	Calf_____	RX Given ☐
Thigh_____	Thigh_____	Insurance ☐
Leg length_____	Leg length_____	Self Pay ☐
		Size_____