Today's Date_____

Leg Pain Questionnaire, Page 1

1. Please describe why you scheduled this appointment:

_____

_____

_____

2. How long have you had symptoms? _____

3. For women, have you had any pregnancies?

☐ Yes ☐ No

If yes, how many? _____

How many live births? _____

4. Which leg(s) are your symptoms present in?

☐ Right ☐ Left ☐ Both ☐ None

5. Do you experience any of the following in your legs/feet?

☐ Aching ☐ Restlessness ☐ Swelling

☐ Heaviness ☐ Itching ☐ Night time cramping

☐ Cramping only while walking ☐ None of the above

☐ Cramping or pain in the legs while standing extended periods of time

☐ Pain in the bottom of the feet or the toes only while legs are elevated

6. If you checked "Cramping only while walking" above, which leg are symptoms in?

☐ Right ☐ Left ☐ Both ☐ None

How long can you walk before you experience symptoms? _____

What improves the symptoms?

☐ Standing still ☐ I have to sit down to resolve them

Do you get the same symptoms if you stand for extended periods of time?

☐ Yes ☐ No

7. If you checked "Pain in the bottom of the feet or the toes only while legs are elevated", does hanging the foot over the side of the bed improve the pain?

☐ Yes ☐ No

8. Do you or have you ever had any open wounds on your legs or feet?

☐ Yes ☐ No

Location: _____

Current or previous treatment: _____

How long have they been present: _____

Leg Pain Questionnaire, Page 2

9. What time of day are your symptoms worse?
☐ Morning ☐ Evening ☐ Night ☐ Same All Day

10. Have you tried any of the following?
☐ Compression stockings ☐ Leg Elevation ☐ Tylenol
☐ Motrin/Ibuprofen/Advil ☐ Other:_____
☐ None of the above

11. If you have tried compression stockings, how often do you wear them and what level of compression do you wear? _____

12. Do you currently or have you ever seen a medical provider for your back?
☐ Yes ☐ No
If "yes", whom, and when was the last time you were seen? _____
If "yes", what kind of treatment(s)/surgeries/injections have you had?

_____
_____
_____

13. Do you sleep in a:
☐ Bed ☐ Chair with feet on floor ☐ Recliner ☐ Couch
☐ Other _____

14. Do you have family history of varicose veins?
☐ Yes ☐ No
If yes, whom?_____

15. Have you ever had a reaction to any metal, or been diagnosed with a metal allergy (ex. Nickle)?
☐ Yes ☐ No
If yes, what was the reaction and when did you have it?_____
_____
If yes, have you seen an allergist, and if so, whom?_____

16. Have you had any outside testing done on your legs?
☐ MRI/MRV ☐ CTA/CTV ☐ Ultrasound ☐ None
Where and when?_____

You must bring CD of your MRI/MRA, CTA/CTV at least one week prior to your appointment for review by medical providers. Report of the study is not enough. This must be done PRIOR to your appointment for review.

17. **Do you have:**

Varicose veins in your legs?	☐ Right	☐ Left	☐ Both	☐ None
Skin color or texture changes in your legs?	☐ Right	☐ Left	☐ Both	☐ None
Large visible veins of the labia or scrotum?	☐ Right	☐ Left	☐ Both	☐ None
Do your symptoms affect quality of your life?	☐ Yes	☐ No		

18. What activities are limited as a result of your symptoms?

_____

_____

_____

_____

19. Have you had any previous treatment on your legs?

Angioplasty/stenting of leg **ARTERIES** ☐
☐ Right ☐ Left
Angioplasty/stenting of leg **VEINS** ☐
☐ Right ☐ Left
Leg Bypass ☐
☐ Right ☐ Left
Amputation of leg(s) ☐
☐ Right ☐ Left
☐ Above knee ☐ Below Knee
Amputation of feet/toes ☐
☐ Right ☐ Left
At which level of the toe/foot: _____
Vein stripping/phlebectomy/ablation/sclerotherapy/etc ☐
☐ Right leg ☐ Left leg
Who performed the procedure(s): _____
Were your symptoms improved following? ☐ Yes ☐ No

20. Do you have history of DVT?
☐ Right ☐ Left
☐ Arm ☐ Leg
When was it diagnosed? _____
How was it treated? _____
Do you have an IVC filter placed? _____

21. Do you have history of Pulmonary Embolism?
☐ Yes ☐ No