Name________________________________ DOB_______________________

Leg Questionnaire - Please be thorough in completing this form - <u>Check all that apply to you:</u>

Have you had:

◯ Previous leg procedure

- ◯ angioplasty / stent of arteries in legs
- ◯ leg bypass
- ◯ amputation → ◯leg: _____ ◯foot/toe:_______
- ◯ vein stripping / phlebectomy in your legs ◯ vein sclerotherapy ◯ vein closure: _________________

Do you have:

◯ Open sores or ulcers on your leg(s) or feet that will not heal?

- Where are the ulcers located?____
- How long have the ulcers been present? _________________________________

◯ <u>Leg pain / discomfort?</u> → ◯right leg ◯left leg ◯both legs

- How many weeks / months / years have you had pain/discomfort:______________
- Pain is described as: ◯aching ◯cramping ◯heavy feeling ◯swelling ◯restless feeling ◯itching
- Severity of pain: ◯mild ◯moderate ◯severe
- Pain is worse at ◯night ◯end of the day ◯with walking? How far can you walk:________________
- Pain is better with ◯elevating legs ◯dangling leg over side of bed ◯compression stocking
- Do you take medicine for leg pain? ◯ Motrin/Ibuprofen ◯ Tylenol ◯ Other: ___________________

◯ Clots in your legs (DVT) ◯ Clots in lungs (PE) ◯ IVC filter (greenfield filter) inserted

◯ Varicose veins: ◯right leg ◯left leg ◯both legs ◯labia/scrotum

◯ Leg discoloration or texture changes ◯right leg ◯left leg ◯both legs

◯ Pelvic pain or pressure?

Do your symptoms negatively affect quality of your life?

- ◯ unable to perform normal household activities
- ◯ unable to perform work activities
- ◯ difficulty sleeping
- ◯ other - describe: ____

Family member who has varicose veins. Please list_________________

Do you use compression stockings? ◯Yes ◯No Duration of use: ____________________

Did you have ultrasound, CTA or MRA of your legs or abdomen? Date:_______ Facility:___________

You must bring CD of your MRA or CTA to your appointment so we may view your images.

Report of the study that is sent to us from your referring physician is not enough.