QUESTIONAIRE FOR NEW VV PATIENTS

NAME_____ AGE_____DATE_____

HOW DID YOU HEAR ABOUT US?_____

REFFERRING PHYSICIAN (IF ANY)_____

DO YOU HAVE?

	RIGHT LEG	LEFT LEG	COMMENTS/EXPLANATION
ACHE	_____	_____	_____
PAIN	_____	_____	_____
TENDERNESS	_____	_____	_____
HEAVINESS	_____	_____	_____
TIGHTNESS	_____	_____	_____
IRRITATION	_____	_____	_____
CRAMPS	_____	_____	_____
OTHER	_____	_____	_____
SWELLING	_____	_____	_____
FAMILY HISTORY	_____	_____	_____

DO YOU NOW OR HAVE YOU EVER HAD?

DERMATITIS	_____	_____	_____
CELLULITIS	_____	_____	_____

BLEEDING _____ _____
_____

ULCERATION _____ _____
_____

DVT/CLOTS _____ _____
_____

PHLEBITIS _____ _____
_____

STRIPPING/SCLERO _ _____ _____
_____

ADDITIONAL INFO
_____

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