Somerset Surgical Associates

Physician/Nurse Varicose Vein Questionnaire

Name:_____ Date: _____

Which leg is affected? ____Left ____Right ____Both

Are you in pain? ____Yes ____No

Does this pain interfere with your daily activities? ____Yes ____No

Did you ever have surgery on your legs? ____Yes ____No
If yes, please explain:_____

Do you take blood thinners? _____Yes _____No
Name of medication:_____

Do you take Motrin, Advil, Tylenol, and/or aspirin for pain? ____Yes ____No

Do you have a history of burning, black and blue marks, or varicose veins in your legs? ____Yes ____No

Do you elevate your legs when resting? ____Yes ____No

Did you ever have sudden onset of difficulty breathing? ____Yes ____No

Did you ever have sleep disturbances accompanied by leg restlessness? ____Yes ____No

Do you have a history of smoking ____Yes ____No
high blood pressure ____Yes ____No
high cholesterol _____Yes ____No
diabetes _____Yes ____No

Did you ever wear support stockings, Ace bandage, or compression stockings? ____Yes ____No

If yes, for how long? _____ What degree of compression? _____

Nurse's Signature:_____ Date: _____

Doctor's Signature:_____ Date: _____

Gunaseelan Ambrose, MD, FACS • Obi J Imegwu, MD, FACS • Cynthia Lee, 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