FOX VEIN EXPERTS

VEIN IN TAKE FORM

Symptoms: *(Please check if yes)*	**R**	**L**
Pain / Aching in legs	□	□
Heaviness	□	□
Tiredness / Fatigue	□	□
Itching / Burning	□	□
Leg Cramping	□	□
Leg restlessness	□	□
Throbbing / Tingling	□	□
Swelling	□	□

Do your symptoms interfere with your sleep? □
Do your symptoms interfere with any activities including prolonged walking or standing? □
Do your symptoms worsen with or after activity? □
Are your symptoms worse at the end of the day? □
On a scale of 1 to 10, with 10 being the worst, I consider my vein disease to be:
Slightly bothersome 1 2 3 4 5 6 7 8 9 10 Severely affecting my life

RLS (Restless Leg Syndrome *(Please check box if yes)*
Do you find the need to move your legs to relieve an uncomfortable feeling? □
Do your legs feel better when moving them or walking? □
Do you constantly move or twitch your legs when resting or sitting? □

Please check box if you've had any of the following:

Prior evaluation for your veins?	□	Any type of blood clot / clotting disorder?	□
Previous vein surgery or laser treatment?	□	If so, were you treated with blood thinners Y/ N	
Previous vein injections?	□	Family history of vein disease?	□
Bleeding from a vein?	□	Family history of leg ulceration?	□
Leg ulceration?	□	Family history of blood clots?	□
Phlebitis (swollen, red or painful vein)?	□		

How long have you had varicose/spider veins? □ 0-5 years □6-10 years □ 10-15 years □15+years
Do any other family members have varicose veins? □ Yes □ No Who? _____
Have you ever had a clot in your legs or pulmonary embolus? □ Yes □ No When?_____
Do you notice any color change in your skin or around the affected area? □ Yes □ No
Do you notice that your feet get swollen at the end of the day? □ Yes □ No

Conservative Treatments Used Commonly or Previously: (please check those measures you have tried)
Pain medications or herbal supplements: □ Yes □ No
Compression stockings □ Yes □ No If so, how long? _____
Leg Elevation □ Yes □ No

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