GRANTS PASS SURGICAL ASSOCIATES P.C.

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VARICOSE VEIN DAILY ACTIVITY QUESTIONNAIRE

(REQUIRED BY INSURANCE)

Patient name _____ DOB _____

Please indicate how your varicose vein symptoms significantly impact specific activities of daily living (excluding "at work" symptoms).

1. Do you have pain when taking a shower or bath?	☐ Yes	☐ No
2. Do you have any bleeding from the veins?	☐ Yes	☐ No
3. Does getting dressed hurt?	☐ Yes	☐ No
4. Does it hurt if you bump your veins?	☐ Yes	☐ No
5. Does it hurt to cross your legs?	☐ Yes	☐ No
6. Do you have pain when preparing a meal?	☐ Yes	☐ No
7. Do you have pain when doing household chores?	☐ Yes	☐ No
8. Does it hurt to garden or mow the grass?	☐ Yes	☐ No
9. Do you have pain with exercise?	☐ Yes	☐ No
10. Do you have pain when grocery shopping?	☐ Yes	☐ No
11. Do you have pain when you bend or squat?	☐ Yes	☐ No
12. Does it hurt when you are sleeping?	☐ Yes	☐ No
13. Does it hurt when your dog or cat jumps on your legs?	☐ Yes	☐ No
14. Does it hurt to sit for an extended period of time?	☐ Yes	☐ No
15. Does it hurt to stand for an extended period of time?	☐ Yes	☐ No
16. Have you been using conservative therapy with the use of medical grade compression stockings (minimum 20mmHg) for at least 3 months?	☐ Yes	☐ No

If yes, please indicate the date you started wearing the compression stockings: _____

Please list any other pertinent symptoms of your varicose veins that have an impact on your daily living that are not listed above: _____

_____

_____

_____

Patient's signature _____ Date _____

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