NORTH SHORE
VEIN CENTER

QUALITY OF LIFE

As best you can, please rate your symptoms with regards to your leg vein disease.

Circle the frequency of each of the symptoms described below as to whether they occur daily, weekly, monthly, etc.

	NEVER	RARELY	MONTHLY	WEEKLY	DAILY	CONSTANT
HEAVINESS	0	1	2	3	4	5
ACHINESS	0	1	2	3	4	5
SWELLING	0	1	2	3	4	5
THROBBING	0	1	2	3	4	5
ITCHING	0	1	2	3	4	5
NIGHT CRAMPS	0	1	2	3	4	5

TOTAL SCORE _____

Have you had a flu shot within the past 12 months? ⬭ YES ⬭ NO

If NO, why not? _____