



**Venous Quality of Life Questionnaire**

**In the past month, to what extent has your veins:**

	<b>Not bothered/ limited at all</b>	<b>A little bothered/ limited</b>	<b>Moderately bothered/ limited</b>	<b>Very bothered/ limited</b>	<b>Extremely bothered/ limited</b>
<b>Caused pain/discomfort</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Interfered with daily activities (ie cooking, cleaning, hobbies, driving, etc.)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Disrupted sleep</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Affected job performance</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Caused embarrassment/self consciousness based on how they look</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

Do your veins cause any other issues not listed above? Please note below.

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Patient Name

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Date

\_\_\_\_\_  
Patient Signature