

# Leg Pain Cons. form

Office Use Only:

**Pt Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Sex: F / M** **MR#:** \_\_\_\_\_

**Referring physician** \_\_\_\_\_ **PCP** \_\_\_\_\_

1. How long has the symptom last / and when did it start worsening? \_\_\_\_\_/\_\_\_\_\_

2. Is the pain constant or intermittent / if it is intermittent, how often does the pain happen / which leg is worse?  
\_\_\_\_\_/\_\_\_\_\_

3. Leg pain description:

	Where		Where
Dull achy	Yes / No ____/10_____	Sharp pain	Yes / No _____
Any sores	Yes / No _____	Weakness	Yes / No _____
Burning	Yes / No _____	Numbness	Yes / No _____
Tingling	Yes / No _____	Pain @ night	Yes / No ____/10_____
Heaviness	Yes / No _____	Tiredness	Yes / No _____
Restless legs	Yes / No _____	Coldness	Yes / No _____
Leg cramping	Yes / No _____	Tenderness	Yes / No _____
Fatigue	Yes / No _____	Throbbing	Yes / No _____
Leg swelling	Yes / No _____	Swollen ankle	Yes / No _____
Itching	Yes / No _____	Purple/Blue toes	Yes / No _____

Pain in the calf when walking Yes / No      Symptoms worse in the morning / at night? \_\_\_\_\_

4. Leg pain symptoms relieved by:

• Pain medications: _____	Any relief? Yes / No	How much did it help? A little / moderate / complete
_____	Yes / No	A little / moderate / complete

• Elevating legs Yes / No      Lowing Legs Yes / No      Compression Hose Yes / No For how long? \_\_\_\_\_

5. Any walking problems?

- Has the walking distance changed? Increased / Decreased / Same (*Please circle one*) \_\_\_\_\_
- How far were you able to walk in the past? \_\_\_\_\_ How far can you walk now? \_\_\_\_\_
- How far can you walk before the pain start? \_\_\_\_\_
- How far can you still walk after the pain? \_\_\_\_\_

6. Are you taking or have you taken any blood thinners? *Please circle* : Pletal, Coumadin, Plavix, Aspirin, Others \_\_\_\_\_

7. Leg pain history:

		Descriptions:
• Have you ever had vein stripping surgery?	Yes / No	_____
• Have you ever had vein injections?	Yes / No	_____
• Have you had phlebitis?	Yes / No	_____
• Have you ever had blood clots / DVT?	Yes / No	_____
• Have you had any test(s) done on your legs?	Yes / No	_____

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Family history: \_\_\_\_\_

**Physician notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

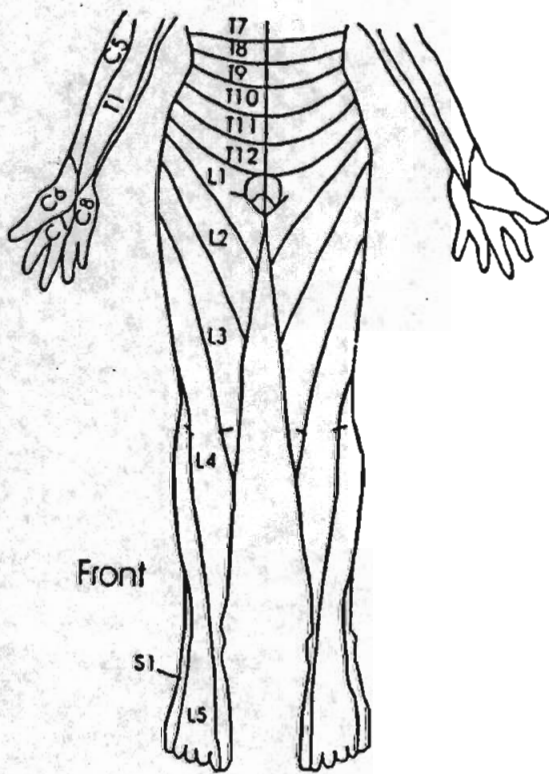


## Leg Pain Diagram

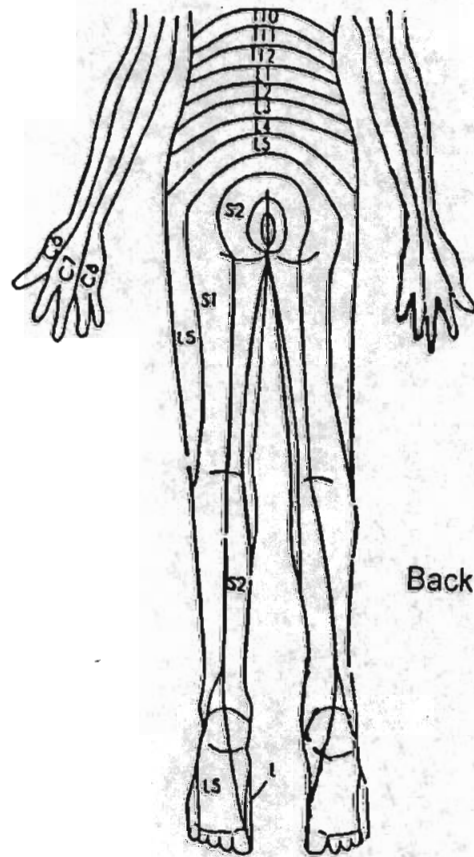
Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please shade in the area you have complained of:



Front



Back

N=numbness T=tingling W=weakness C=cramping

B=burning

P=pain, scale 1, 2, 3, 4, 5, 6, 7, 8, 9, 10