LSU Health
Healthcare Network

Leg Pain History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: Female Male

Email Address: _____

1.Do you have leg pain? ☐ Yes ☐ No
Right Left Both Right worse Left worse

2.What type of leg pain? **Severity 1 – 10 (1: no pain; 10: worst pain)** _____
Throbbing Aching Dull Stabbing Nighttime cramping Burning

3.What type of sensations do you have in your legs?
Heaviness Tiredness Tenderness Itching Tingling Numbness Restlessness

4.When does the leg pain occur?
All day Starts mid-day Starts end of day At night

5.How long have you had the pain in your legs?
Days _____Months _____Years Has it progressed over time? ☐ Yes ☐ No

6.Leg pain worsens with . . .
Standing Prolonged standing Driving Sitting Lying down

7.Leg pain worsens with . . .
Heat Cold Pregnancy Menstrual Cycle Your job _____

8.Leg pain better with . . .
Rest Elevation Sitting Walking Standing

9.Do you take any medication for the leg pain?_____

10.Do you have any sensation in your varicose veins? Itching Burning Aching Throbbing

11.Do you have any swelling of your legs? ☐ Yes ☐ No
Right Left Both More on right More on left

12.Have you worn compression hose? ☐ Yes ☐ No
How long? _____