

**10. Indicate which of the following problems you have experienced:**

	<u>Right Leg</u>	<u>Left Leg</u>	<u>How Many Years?</u>
<b>a. Pain in your:</b>			
Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	_____
Calf	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foot	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other - please specify	_____		
<b>b. Swelling of the legs</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**11. If you experienced pain in your lower limbs:**

	<u>Yes</u>	<u>No</u>
<b>a. Is the pain exacerbated by:</b>		
Extended periods in standing position	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>
Exercising and/or walking	<input type="checkbox"/>	<input type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>
Other - please specify	_____	
<b>b. Is the pain alleviated by:</b>		
Elevation of the limbs	<input type="checkbox"/>	<input type="checkbox"/>
Elastic stockings	<input type="checkbox"/>	<input type="checkbox"/>
Walking and/or exercising	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. Indicate the type of pain</b>		
Resting pain	<input type="checkbox"/>	<input type="checkbox"/>
Resting cramps	<input type="checkbox"/>	<input type="checkbox"/>
Night cramps	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness in the legs	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Pain in specific areas	_____	