VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

DOB: _____ Sex: ☐M ☐F Insurance Provider: _____

How did you hear about us? _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg:	☐R ☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg:	☐R ☐L
Blood clots	☐Y ☐N	Leg:	☐R ☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg:	☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg:	☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg:	☐R ☐L
Heaviness	☐Y ☐N	Leg:	☐R ☐L
Tiredness/fatigue	☐Y ☐N	Leg:	☐R ☐L
Itching/burning	☐Y ☐N	Leg:	☐R ☐L
Swelling	☐Y ☐N	Leg:	☐R ☐L
Cramps	☐Y ☐N	Leg:	☐R ☐L
Restless legs	☐Y ☐N	Leg:	☐R ☐L
Throbbing	☐Y ☐N	Leg:	☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg:	☐R ☐L
Other:	☐Y ☐N	Leg:	☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What?	_____
Elevation of legs	☐Y ☐N	What?	_____
Wear support hose	☐Y ☐N	What?	_____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who?	_____
Vein stripping	☐Y ☐N	Who?	_____
Blood coagulation disorder	☐Y ☐N	Who?	_____
Blood clots	☐Y ☐N	Who?	_____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who?	_____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

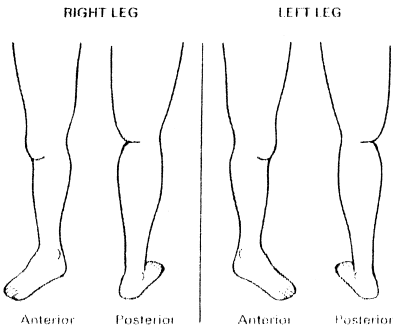
Sclerotherapy	☐Y ☐N	Leg:	☐R ☐L
Laser therapy (spider veins)	☐Y ☐N	Leg:	☐R ☐L
Phlebectomy	☐Y ☐N	Leg:	☐R ☐L
Vein stripping surgery	☐Y ☐N	Leg:	☐R ☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg:	☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐Y ☐N	
Prolonged sitting periods	☐Y ☐N	
Do you exercise regularly?	☐Y ☐N	
Do you smoke?	☐Y ☐N	
Pregnancies	☐Y ☐N	How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:

☐ Chronic venous insufficiency ☐R ☐L
☐ Other: _____ ☐R ☐L

Treatment Plan:

☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: _____ ☐R ☐L

Screening Provider Signature: _____

Follow-Up Appointment

Date: _____ Time: _____

Physician: _____

Physician Phone Number:

NOTES: