

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 | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Phlebitis (vein redness/tenderness) | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Blood clots | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Deep vein thrombosis (DVT) | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Saphenous vein reflux | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |

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

- | | | |
|------------------------|---|--|
| Aching/pain | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Heaviness | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Tiredness/fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Itching/burning | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Swelling | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Cramps | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Restless legs | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Throbbing | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Skin or ulcer problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Other: | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |

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

- | | | |
|---------------------|---|-------------|
| Medication for pain | <input type="checkbox"/> Y <input type="checkbox"/> N | What? _____ |
| Elevation of legs | <input type="checkbox"/> Y <input type="checkbox"/> N | What? _____ |
| Wear support hose | <input type="checkbox"/> Y <input type="checkbox"/> N | What? _____ |

II. Family History

Have any of your family members had:

- | | | |
|---|---|------------|
| Varicose veins | <input type="checkbox"/> Y <input type="checkbox"/> N | Who? _____ |
| Vein stripping | <input type="checkbox"/> Y <input type="checkbox"/> N | Who? _____ |
| Blood coagulation disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Who? _____ |
| Blood clots | <input type="checkbox"/> Y <input type="checkbox"/> N | Who? _____ |
| Stroke, heart attacks or pulmonary emboli | <input type="checkbox"/> Y <input type="checkbox"/> N | Who? _____ |

III. Vein Treatment History

Have you ever been treated for varicose veins with:

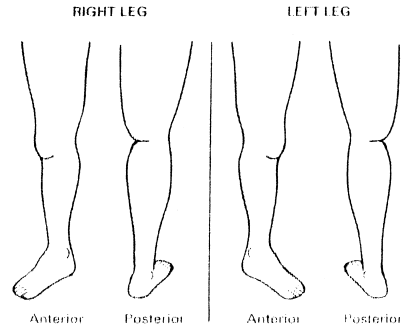
- | | | |
|--|---|--|
| Sclerotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Laser therapy (spider veins) | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Phlebectomy | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| Vein stripping surgery | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |
| RF ablation (VNUS Closure [®]) | <input type="checkbox"/> Y <input type="checkbox"/> N | Leg: <input type="checkbox"/> R <input type="checkbox"/> L |

IV. Personal Activities List

Does your work require:

- | | | |
|----------------------------|---|-----------------|
| Prolonged standing periods | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Prolonged sitting periods | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Do you exercise regularly? | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Do you smoke? | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Pregnancies | <input type="checkbox"/> Y <input type="checkbox"/> N | How many? _____ |

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



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> No signs of venous disease | <input type="checkbox"/> Spider veins |
| <input type="checkbox"/> Visible varicose veins | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Pigmentation <input type="checkbox"/> Healed ulcers | <input type="checkbox"/> Active ulcers |

LEFT LEG (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> No signs of venous disease | <input type="checkbox"/> Spider veins |
| <input type="checkbox"/> Visible varicose veins | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Pigmentation <input type="checkbox"/> Healed ulcers | <input type="checkbox"/> Active ulcers |

Clinical Assessment:

- | | |
|---|---|
| <input type="checkbox"/> Chronic venous insufficiency | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> R <input type="checkbox"/> L |

Treatment Plan:

- | | |
|--|---|
| <input type="checkbox"/> Duplex ultrasound | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Medical compression stockings | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> R <input type="checkbox"/> L |

Screening Provider Signature: _____

Follow-Up Appointment

Date: _____ Time: _____

Physician: _____

Physician Phone Number: _____

NOTES: