VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

Phone: _____ Insurance Provider: _____

Email: _____

DOB: _____ Sex: ☐M ☐F

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:

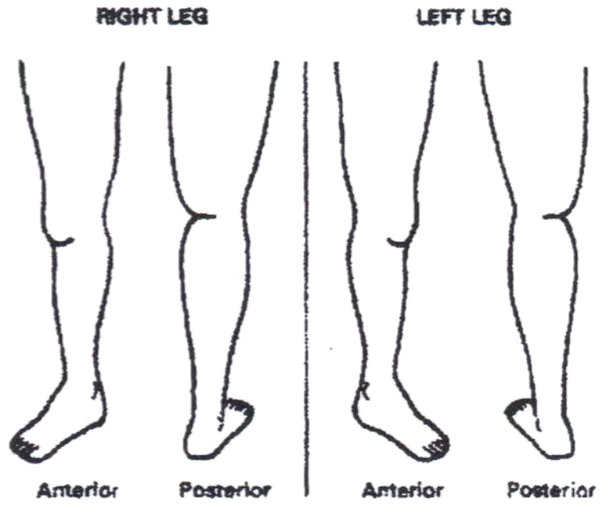
Sclerotherapy	☐ Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐ Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐ Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐ Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐ Y ☐N	Leg: ☐R ☐L

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: