VEIN SCREENING FORM

Please complete left side of form only.

Date: ______ Appt Time: ______

Name: ______

Phone: ______

Email: ______

DOB: ______ Sex: ☐M ☐F

Screening Provider: ______

Primary Care Physician: ______

Insurance Provider: ______

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:

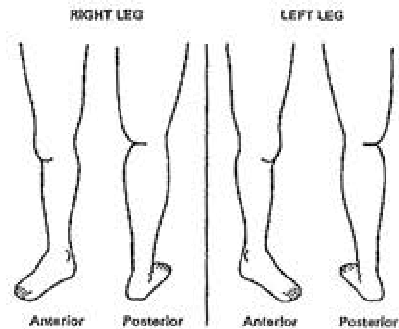
Sclerotherapy	☐ Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐ Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐ Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐ Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐ Y ☐N	Leg: ☐R ☐L

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: