VEIN SCREENING FORM

COMPREHENSIVE INTEGRATED CARE
Passionate People • Compassionate Care

HEIGHT_____
WEIGHT_____

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
Labial/vaginal veins	□Y □N	Leg: □R □L
Scrotal veins	□Y □N	Leg: □R □L
Ruptured veins	□Y □N	Leg: □R □L

Do you have any of the following:

Red spider veins	□Y □N	Leg: □R □L
Skin discoloration below the knee	□Y □N	Leg: □R □L
Purple veins	□Y □N	Leg: □R □L
Bulging veins	□Y □N	Leg: □R □L
Flat bluish-green veins	□Y □N	Leg: □R □L
Abdominal veins	□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	□Y □N	Leg: □R □L
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
Ulcer problems/ankle sores	□Y □N	Leg: □R □L
Discomfort around menstrual period	□Y □N	Leg: □R □L

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	
Currently pregnant:	□Y □N	
Breastfeeding	□Y □N	
Pregnancies	□Y □N	How many ?___

Number of stillbirths/miscarriages _____

Do your leg problem/symptoms negatively limit you in the following activities:

Daily activities at work □Y □N

Daily activites at home (housework, childcare, gardening, jobs/repairs, etc.) □Y □N

Social or leisure activities in which you are standing for long periods (parties, family gatherings, shopping, etc) □Y □N

Social or leisure activities in which you are sitting for long periods (cinema, theatre, traveling, etc.) □Y □N

Does walking/exercise relive your discomfort or make it worse? _____

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

Medication for pain □Y □N Earliest date started: _____ What: _____ Outcome_____

Wear support hose □Y □N Earliest date started: _____ What: _____ Outcome_____

How long have you worn compression hose over the course of your life? _____months _____years

Physician who prescribed compression hose:_____ Strength and date prescribed_____

Elevation of legs □Y □N

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	□Y □N	Who? _____
Pulmonary emboli	□Y □N	Who? _____