VEIN SCREENING FORM

Patient Name: ______________________________ **Date of Birth:** _______________

Directions: Please answer the following questions. **Pt screened by:**____________

Do you experience any of the following in your legs?

Symptom				
Aching/pain?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Heaviness?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Swollen ankles?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Tiredness/fatigue?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Itching/burning?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Numbness/tingling?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Leg cramps?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Restless legs?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Throbbing?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Skin discoloration?	☐ Yes	☐ No	☐ One leg	☐ Both legs

Past Medical History

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? ____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? ______________________________
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? ____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? ____
5. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
   If yes, when and what type of test and where on the leg? ______________________________
   ____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Relative		
Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

Criteria for provider evaluations met? ☐ Yes ☐ No

Patient appointment date/time/location: ____

Patient address: ____

Phone: ____