VEIN SCREENING- INITIAL VISIT

Date: ______________ Name: _________________________________ DOB: _____________ Male/Female

Primary Care Physician: ____________________________ Screening Physician:__________________________

Please circle your answers to ALL the questions below.

Vascular History

Do you have OR have ever been diagnosed with:

Varicose veins: Yes No Right leg Left leg
Vein stripping: Yes No Right leg Left leg
Phlebitis: Yes No Right leg Left leg
DVT (blood clot): Yes No Right leg Left leg

Do you experience any of the following in your legs:

Aching/pain: Yes No Right leg Left leg
Heaviness: Yes No Right leg Left leg
Tiredness/fatigue: Yes No Right leg Left leg
Itching/burning: Yes No Right leg Left leg
Swelling: Yes No Right leg Left leg
Cramps: Yes No Right leg Left leg
Restless legs: Yes No Right leg Left leg
Throbbing: Yes No Right leg Left leg
Skin/ulcer problems: Yes No Right leg Left leg

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

Medication for pain Yes No
List medication: ______________________________
Elevation of legs: Yes No How often_________
Wear support hose: Yes No How often_________

Family History

Have any of your family members had:

Varicose veins: Yes No Right leg Left leg
Vein stripping: Yes No Right leg Left leg
Blood clots: Yes No Right leg Left leg
Blood coagulation: Yes No Right leg Left leg
Stroke,heart attacks
Or pulmonary emboli: Yes No Right leg Left leg

Vein Treatment History

Sclerotherapy: Yes No Right leg Left leg
Laser therapy: Yes No Right leg Left leg
Phlebectomy: Yes No Right leg Left leg
Vein stripping: Yes No Right leg Left leg
Endovenous ablation: Yes No Right leg Left leg

Personal Activities

Prolonged standing: Yes No How long__________
Prolonged sitting: Yes No How long__________
Do you exercise? Yes No
How often and what do you do?
____

Do you smoke? Yes No
Have you ever been pregnant? Yes No
How many? ______________

Which ADL's do you find difficult to perform due to your leg symptoms?

Feeding Yes No
Toileting Yes No
Grooming Yes No
Bathing Yes No
Getting dressed Yes No
Walking Yes No
Shopping Yes No
Cooking Yes No
Housekeeping Yes No
Managing Medications Yes No
Managing Money Yes No
Using telephone Yes No
Other ____

Treatment Plan * Physician Only*

Doppler ultrasound Right leg Left leg
Medical compression stockings-
prescribed Right leg Left leg
NSAID
Other ________________ Right leg Left leg

Ordered by :

________________________, MD