VEIN SCREENING FORM
Please complete left side of form only.

Date: ____________ Appt Time: ____________ Screening Provider: ____________

Name: ____________ Primary Care Physician: ____________

DOB: ____________ Sex: ☐ M ☐ F Insurance Provider: ____________

How did you hear about us? ____________

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:

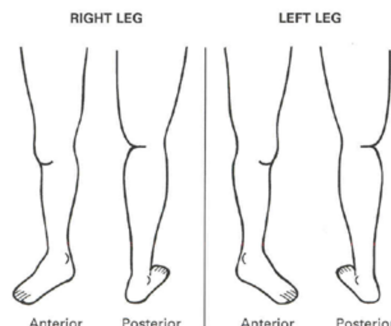
Sclerotherapy	☐ Y ☐ N	Leg: ☐ R ☐ L
Laser therapy (spider veins)	☐ Y ☐ N	Leg: ☐ R ☐ L
Phlebectomy	☐ Y ☐ N	Leg: ☐ R ☐ L
Vein stripping surgery	☐ Y ☐ N	Leg: ☐ R ☐ L
RF ablation (VNUS Closure®)	☐ Y ☐ N	Leg: ☐ R ☐ L

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: