

|  |  |  |  |
| --- | --- | --- | --- |
| Vein SCREENING ASSESSMENT | | | |
| Name: |  | Date Of Birth: |  |
| Primary Insurance: | | Secondary Insurance: | |
| Sex ÿ M ÿ F | Date of Birth: | How did you hear about us? | |

**HISTORY**

Have you ever had varicose veins or bulging veins? ÿ Yes ÿ No

**SIGNS AND SYMPTOMS**

Do you experience any of the following in your legs or ankles?

ÿ Leg pain, aching or cramping

ÿ Burning or itching of the skin

ÿ Leg or ankle swelling, especially at the end of the day

ÿ “Heavy” feeling in legs

ÿ Varicose veins

ÿ Skin discoloration or texture changes, such as above the inner ankle

ÿ Open wounds or sores, such as above the inner ankle

ÿ Restless legs

**RISK FACTORS**

Has anyone in your family ever had varicose veins? ÿ Yes ÿ No

Have you had any treatments or procedures for vein problems? ÿ Yes ÿ No

Do you sit or stand for long periods of time, such as at work? ÿ Yes ÿ No

Do you frequently engage in heavy lifting? ÿ Yes ÿ No

Have you ever had varicose veins or bulging veins? ÿ Yes ÿ No

**Additional Notes**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name**