

WINDOM AREA HEALTH VEIN SCREENING FORM

Patient Name: _____ DOB: _____ Age: _____ Date: _____
 Primary Healthcare Provider: _____

Vascular History (please check all that apply)

Do you have or have you ever been diagnosed with:

- Blood Clots Leg: R L
- Deep Vein Thrombosis (DVT) Leg: R L
- Phlebitis (redness/tenderness) Leg: R L
- Saphenous Vein Reflux Leg: R L
- Varicose Vein Problems Leg: R L

Do you experience any of the following in your legs?

- Aching/Pain Leg: R L Skin/Ulcer problems Leg: R L
- Cramps Leg: R L Swelling Leg: R L
- Heaviness Leg: R L Throbbing Leg: R L
- Itching/Burning Leg: R L Tiredness/Fatigue Leg: R L
- Restless Legs Leg: R L Other _____ Leg: R L

Number of days per week that legs cause discontent _____ Overall satisfaction with legs _____ (0= Dissatisfied, 10= Satisfied)

Which of the following do you currently do to improve leg symptoms? (please check all that apply)

- Elevation of legs Leg: R L
- Medication for pain Leg: R L
- Wear support Hose Leg: R L

Vein Treatment History

Have you ever been treated for varicose veins with:

- Laser Therapy (Spider Veins) Leg: R L
- Phlebectomy Leg: R L
- RF Ablation Leg: R L
- Sclerotherapy Leg: R L
- Vein Stripping Surgery Leg: R L

Personal Activities List

Please check all that apply:

- My work requires me to stand for prolonged periods of time
- My work requires me to sit for prolonged periods of time
- I exercise regularly
- I smoke
- I have been pregnant Number of pregnancies _____

Family History Has any member of your immediate family ever had any of the following conditions:

(Please check all that apply)

- Blood Clots
- Blood Coagulation Disorder
- Stroke, Heart Attack, or Pulmonary Embolism
- Varicose Veins
- Vein Stripping

Family Member

Surgical History

List previous hospitalizations/Surgeries When

Social History

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously Current packs/day _____

Use of Drugs: Never Previously Current / type _____

Family Medical History (Please list any family medical history of diabetes, high blood pressure, heart disease, stroke, cancer, etc.)

Father: _____ Mother: _____

Siblings: _____ Children: _____

Maternal Grandparents: _____ Paternal Grandparents: _____

Medical History and Review of Systems

Do you now have or have you had any problems related to the following body systems? Please explain any yes answers in the comments space provided below each section.

GENERAL SYMPTOMS

Good general health lately	No	Yes
Recent weight loss	No	Yes
Acute infections	No	Yes
Fever	No	Yes

Comments: _____

EYES

Wear glasses/contact lenses	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes

Comments: _____

ENT

Infection	No	Yes
Snoring	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Sore throat or voice change	No	Yes

Comments: _____

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics	No	Yes
Iodine or other antiseptic	No	Yes
Anesthetics	No	Yes
Morphine, Demerol, other narcotics	No	Yes
Latex	No	Yes

Comments: _____

CARDIOVASCULAR

Chest pain	No	Yes
Stent placement	No	Yes
Fainting	No	Yes
Arrhythmia	No	Yes
Murmur	No	Yes
Hypertension	No	Yes
Stroke	No	Yes

Comments: _____

RESPIRATORY

Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Frequent coughing	No	Yes

Comments: _____

GASTROINTESTINAL

Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Loss of appetite	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes
Heartburn	No	Yes
Hemorrhoids	No	Yes
Diarrhea	No	Yes

Constipation	No	Yes
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Comments: _____

GENITOURINARY

Urinary concerns	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Frequent urinary infections	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Comments: _____

MUSCULOSKELETAL

Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Difficulty in walking	No	Yes
Joint pain	No	Yes
Numbness or tingling sensations	No	Yes

Comments: _____

SKIN

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Swelling of feet, ankles or hands	No	Yes

Comments: _____

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

Comments: _____

PSYCHIATRIC

Memory loss or confusion	No	Yes
Depression	No	Yes
Sleep problems	No	Yes
Recent change in mood	No	Yes

Comments: _____

ENDOCRINE

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

Comments: _____

HEMATOLOGIC/LYMPHATIC

Blood clot	No	Yes
Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes

Comments: _____