PHYSICIANS' CLINIC
of Iowa, P.C.

VEIN SCREENING FORM

Today's Date ____________ Appointment Time ____________ Screening Provider ____________

First Name ____________ Last Name ____________

Date of Birth ____________ Age ________ Gender: ☐ Male ☐ Female

Family Physician ____________ Insurance Provider ____________

How did you hear about us? ____________

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 (Vein 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
- ☐ Cramps — Leg: ☐ R ☐ L
- ☐ Heaviness — Leg: ☐ R ☐ L
- ☐ Itching/Burning — Leg: ☐ R ☐ L
- ☐ Restless Legs — Leg: ☐ R ☐ L
- ☐ Skin or Ulcer Problems — Leg: ☐ R ☐ L
- ☐ Swelling — Leg: ☐ R ☐ L
- ☐ Throbbing — Leg: ☐ R ☐ L
- ☐ Tiredness/Fatigue — Leg: ☐ R ☐ L
- ☐ Other: ____________ Leg: ☐ R ☐ L

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

- ☐ Yes ☐ No Elevation of legs — Please explain: ____________
- ☐ Yes ☐ No Medication for pain — Please explain: ____________
- ☐ Yes ☐ No Wear support hose — Please explain: ____________

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

	Condition	Family Member
☐ Yes ☐ No	Blood Clots	____________
☐ Yes ☐ No	Blood Coagulation Disorder	____________
☐ Yes ☐ No	Stroke, Heart Attack, or Pulmonary Embolism	____________
☐ Yes ☐ No	Varicose Veins	____________
☐ Yes ☐ No	Vein Stripping	____________

VEIN TREATMENT HISTORY:

Have you ever been treated for varicose veins with the following?

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

PERSONAL ACTIVITIES LIST:

(please check all that apply)

- ☐ Yes ☐ No My work requires me to stand for prolonged periods of time.
- ☐ Yes ☐ No My work requires me to sit for prolonged periods of time.
- ☐ Yes ☐ No I exercise regularly.
- ☐ Yes ☐ No I smoke.
- ☐ Yes ☐ No I have been pregnant before. Number of pregnancies? ________

OFFICE USE ONLY. TO BE COMPLETED BY YOUR SCREENING PROVIDER.

Physical Exam ____________

CEAP Clinical Signs ____________

RIGHT LEG *(check all that apply)*

☐ No signs of venous disease ☐ Active Ulcers ☐ Edema ☐ Spider Veins
☐ Visible signs of varicose veins ☐ Healed Ulcers ☐ Pigmentation

LEFT LEG *(check all that apply)*

☐ No signs of venous disease ☐ Active Ulcers ☐ Edema ☐ Spider Veins
☐ Visible signs of varicose veins ☐ Healed Ulcers ☐ Pigmentation

Clinical Assessment:

Chronic venous insufficiency Leg: ☐ R ☐ L Other: ____________ Leg: ☐ R ☐ L

Treatment Plan:

☐ Duplex Ultrasound ☐ Compression Stockings
☐ Sclerotherapy ☐ Other: ____________

Screening Provider Signature: ____________