

Vein Screening Assessment

Patient Name: _____ **Date of Birth:** _____

Check all that apply: **Left Leg** **Right Leg**

- Aching/Pain
- Heaviness
- Swelling
- Skin discoloration
- Restless legs
- Throbbing

Symptoms relieved by rest/elevation

Have your veins gotten worse in recent months?

Yes No

Do you take any medication for pain?

(i.e. Advil, Motrin) Yes No

If yes, what medication/dosage _____

Do you wear prescription compression stockings?

Yes No

Have you ever tried exercising to relieve pain?

Yes No

Have you ever had vein stripping surgery?

Yes No

Have you ever had vein injections?

Yes No

Have you ever had phlebitis?

Yes No

Have you ever had a blood clot?

If yes, when and which leg? Yes No

Do you elevate your legs to relieve discomfort?

Yes No

PHYSICIAN TO COMPLETE BELOW THIS POINT

CEAP CLASS – RIGHT LEG						
0	1	2	3	4	5	6
Asymptomatic	Spider Veins	Varicose Veins	Edema	Skin Changes	Healed Ulcer	Active Ulcer

CEAP CLASS – LEFT LEG						
0	1	2	3	4	5	6
Asymptomatic	Spider Veins	Varicose Veins	Edema	Skin Changes	Healed Ulcer	Active Ulcer

Etiology: Congenital Primary Disease Secondary Disease

Anatomic Findings: Superficial Deep Perforator

Pathophysiology Dysfunction: Reflux Obstruction Both Reflux & Obstruction

Prescribed Compression Stockings Follow up with ultrasound

Notes: _____

Physician Signature: _____ **Date:** _____