Vein Screening Questionnaire

KALLAL MEDICAL GROUP

Date: _____

Name: _____ DOB: _____ Sex: ☐ M ☐ F

VASCULAR HISTORY *Do you have or have you ever been diagnosed with:*

Phlebitis (Vein Redness) (I80.3)	☐ Y ☐ N	Leg: ☐ R ☐ L
Blood Clots (D68.8)	☐ Y ☐ N	Leg: ☐ R ☐ L
Deep Vein Thrombosis (DVT) (Z86.72)	☐ Y ☐ N	Leg: ☐ R ☐ L
Vein Thrombosis or Embolism (Z86.718)	☐ Y ☐ N	Leg: ☐ R ☐ L
Hemorrhage of Varicosities (R58)	☐ Y ☐ N	Leg: ☐ R ☐ L

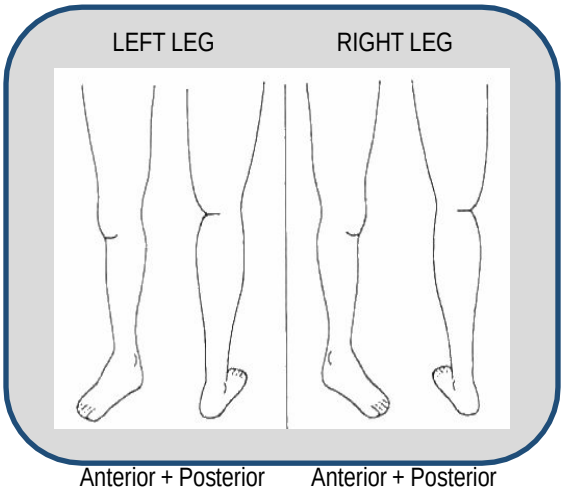
VEIN TREATMENT HISTORY *Have you ever been treated with:*

Sclerotherapy	☐ Y ☐ N	Leg: ☐ R ☐ L	Year: _____
Laser Therapy (Spider Veins)	☐ Y ☐ N	Leg: ☐ R ☐ L	Year: _____
Phlebectomy	☐ Y ☐ N	Leg: ☐ R ☐ L	Year: _____
Vein Stripping Surgery	☐ Y ☐ N	Leg: ☐ R ☐ L	Year: _____
RF Ablation (VNUS Closure®)	☐ Y ☐ N	Leg: ☐ R ☐ L	Year: _____

FAMILY HISTORY *Have any of your family members had:*

Varicose Veins	☐ Y ☐ N	Who: _____
Vein Stripping	☐ Y ☐ N	Who: _____
Leg Ulcers / Swelling	☐ Y ☐ N	Who: _____
Blood Clots (Z83.2)	☐ Y ☐ N	Who: _____
Stroke/ Heart Attack (Z82.49)	☐ Y ☐ N	Who: _____

Please indicate on the diagram below, where your symptoms are most severe and/or skin problem(s)



Anterior + Posterior Anterior + Posterior

CURRENT VEIN HISTORY *Please answer the following very carefully, as it will help your insurance company decide if the recommended procedures are a covered benefit.*

Do you experience ANY of the following symptoms that interfere in activities of daily living?

Aching / Pain	Leg: ☐ L ○ Mild ○ Moderate ○ Severe	☐ R ○ Mild ○ Moderate ○ Severe
Heaviness	Leg: ☐ L ○ Mild ○ Moderate ○ Severe	☐ R ○ Mild ○ Moderate ○ **Severe**
Tiredness / Fatigue	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Itching / Burning	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Swelling Leg / Ankle	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Leg Cramps	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Restless Legs	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Skin Discoloration	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Skin Texture Changes	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Eczema, Flaky Skin, Waxy Skin	Leg: ☐ L ○ Mild ○ Moderate ○ Severe	☐ R ○ Mild ○ Moderate ○ **Severe**
Skin Ulcer Problems	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**
Numbness / Tingling	Leg: ☐ L ○ Mild ○ Moderate ○ **Severe**	☐ R ○ Mild ○ Moderate ○ **Severe**

SOCIAL HISTORY

Have you ever experienced any allergies to adhesives? (i.e., Band-aids, Nail glue, Eyelash glue) ☐ Y ☐ N

Do you have a history of migraines? ☐ Y ☐ N

How many pregnancies have you had, if any? _____

Do you smoke tobacco? ☐ Y ☐ N _____ packs/day?

CONSERVATIVE MEASURES (please check all conservative measures you currently use or have previously used)

☐ Pain Medications ☐ Exercise ☐ Leg Elevation ☐ Weight Loss ☐ Compression Stockings (if yes, see below)

How long did you wear compression stockings? _____ months/years Stocking Size: _____

Did you get relief of your symptoms? ☐ Y ☐ N

What kind of pain medication do you take (i.e., Aspirin, Ibuprofen, Aleve)? _____

How many times/mgs per day? _____

LIFESTYLE/PERSONAL ACTIVITES

Tell us what kind of work you do by completing the following sentence: (If you're retired, what work did you do before)

I work/worked as a/an _____ which requires/required _____ hours of standing and/or _____ hours of sitting per day.

Describe how your symptoms are interfering with your essential job functions, daily home, or lifestyle activities: _____