BLESSING
Physician Services

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Vein Screening Questionnaire

Date: ______________________________

Name: ______________________________ DOB: ____________________________________

Phone: ______________________________ Email: ____________________________________

Do you have varicose veins? □ YES □ NO Which leg? _______________________________

Do you have spider veins? □ YES □ NO Which leg? _______________________________

Any previous vein procedures? □ YES □ NO If yes, what type? __________________________

Do you wear, or have been told to wear support stockings? □ YES □ NO If yes, when? _________

Do you have any of the following signs/symptoms of vein disease in your legs?

Aching/Pain	□ YES □ NO	Heaviness	□ YES □ NO
Tired/Fatigue	□ YES □ NO	Itching	□ YES □ NO
Burning	□ YES □ NO	Swollen Legs	□ YES □ NO

Do you have a family history of vein problems? □ YES □ NO

Do you ever have blood clots? □ YES □ NO