Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Venous Insufficiency Screening

Name: _____ DOB: _____ Medical Record #: _____

Patient Signature **X** _____ Date: _____

Have you ever been diagnosed with or do you have any of the following? Please circle your answer.

Varicose Veins	Yes	No	Right Leg	Left Leg
Leg or Ankle Ulcers	Yes	No	Right Leg	Left Leg
Spider Veins	Yes	No	Right Leg	Left Leg
Aching/Pain	Yes	No	Right Leg	Left Leg
Heaviness	Yes	No	Right Leg	Left Leg
Tiredness/Fatigue	Yes	No	Right Leg	Left Leg
Itching/Burning	Yes	No	Right Leg	Left Leg
Swelling	Yes	No	Right Leg	Left Leg
Cramps	Yes	No	Right Leg	Left Leg
Restless Legs	Yes	No	Right Leg	Left Leg
Throbbing	Yes	No	Right Leg	Left Leg
Skin or Ulcer Problems	Yes	No	Right Leg	Left Leg

Do you do any of the following to improve the discomfort in your leg(s)?

Take medication for pain? Yes No; If yes, which medication _____

Elevate your leg? Yes No; If yes, for how long _____

Wear support hose? Yes No; If yes, which type _____

How does your leg condition affect your daily activities? _____

Personal & Family History:

Does anyone in your family have Varicose Veins? Yes No; If yes, whom _____

FEMALES – Have you ever been pregnant? Yes No; If yes, how many times _____

Do you sit or stand for long periods of time? Yes No; If yes, how often _____

Doctor's Signature **X** _____ Date: _____