PATIENT SELF-ASSESSMENT

Patient Name: _____ Date of Birth: _____/_____/_____

Today's Date: _____/_____/_____

Patient Self-Assessment

Please take this self-assessment to see if you might be a candidate for additional screening for potential varicose veins and / or chronic venous insufficiency.

History

Have you ever had varicose veins?	○ Yes	○ No

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Do you experience leg pain, aching or cramping?	○ Yes	○ No
Do you experience leg or ankle swelling, especially at the end of the day?	○ Yes	○ No
Do you feel "heaviness" in your legs?	○ Yes	○ No
Do you experience restless legs?	○ Yes	○ No
Do you have skin discoloration or texture changes?	○ Yes	○ No
Do you have open wounds or sores?	○ Yes	○ No

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with venous reflux disease or chronic venous insufficiency?	○ Yes	○ No
Have you had any treatments of procedures for vein problems?	○ Yes	○ No
Do you stand for long periods of time, such as at work?	○ Yes	○ No

Self-Assessment Results

If you answered yes to one or more of the above questions, please contact us for a consultation to see if you may be candidate for venous reflux disease.