

WEST END VEIN CARE / LOUISE D. FERLAND, MD., FRCSC.

VEIN SCREENING FORM / Please **COMPLETE LEFT Side ONLY**

Patient Name: _____

Phone Number: _____

Address: _____

Date of Birth: _____

Social Security Number: __ : _____

Primary Insurance: _____

Secondary Insurance: _____

TODAY'S DATE: _____

V. Vein Screening-Dr.Ferland will complete..

I. VASCULAR HISTORY

Do you have or have you ever been diagnosed with:

- Varicose vein problems Y N
- Phlebitis (vein redness/tenderness) Y N
- Blood Clots Y N
- Deep Vein Thrombosis (DVT) Y N
- Saphenous Vein Reflux Y N

- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L

Do you experience any of the following in your leg(s)?

- Aching/pain Y N
- Heaviness Y N
- Tiredness/ Fatigue Y N
- Swelling Y N
- Cramps Y N
- Resless Legs Y N
- Throbbing Y N
- Skin or Ulcer Problems Y N
- Other: Y N

- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L

Which of the following do you currently do to improve your leg vein symptoms:

- Medication for Pain Y N
- Elevation of legs Y N
- Wear support Hose Y N

- What? _____
- When? _____
- When? _____

II. FAMILY HISTORY

Have any of your family members had:

- Varicose Veins Y N
- Vein Stripping Y N
- Blood coagulation disorder Y N
- Blood Clots Y N
- Stroke, heart attacks or Pulmonary emboli Y N

- Who? _____
- Who? _____
- Who? _____
- Who? _____
- Who? _____

III. VEIN TREATMENT HISTORY

Have you ever been treated for varicose veins with:

- Sclerotherapy Y N
- Laser Therapy (spider veins) Y N
- Phlebectomy Y N
- Vein Stripping Surgery Y N
- RF Ablation (VNUS Closure) Y N

- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L
- Leg: R L

IV. PERSONAL ACTIVITIES LIST

Does your work require:

- Prolonged standing periods Y N
- Prolonged sitting periods Y N
- Do you exercise regularly? Y N
- Do you smoke? Y N
- Pregnancies Y N

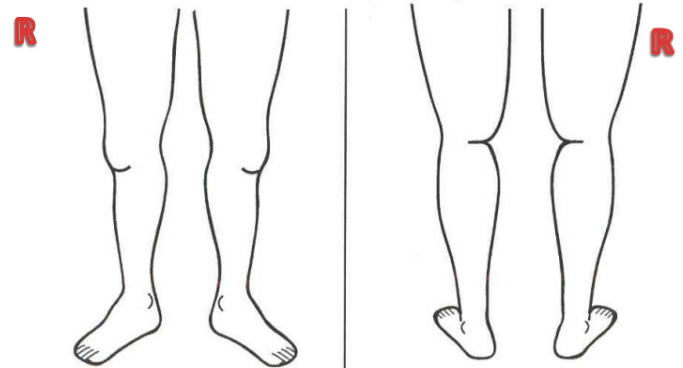
* _____

doctor SIGNATURE: * _____

*patient signature/date

FRONT VIEW

BACK VIEW



R ankle _____ L ankle _____
 R calf _____ L calf _____
 R thigh _____ L thigh _____

PHYSICAL EXAM:

RIGHT LEG (Check all that apply)

- No signs of venous disease
- Visible/palpable varicose veins
- Pigmentation Healed ulcers
- Spider veins
- Edema
- Active ulcers

LEFT LEG (Check all that apply)

- No signs of venous disease
- Visible/palpable varicose veins
- Pigmentation Healed ulcers
- Spider veins
- Edema
- Active ulcers

CLINICAL ASSESSMENT:

- Chronic venous insufficiency R L
- Other: _____ R L

TREATMENT PLAN:

Bilat Duplex 93970	Unilat. Duplex93971
<input type="checkbox"/> Sclerotherapy	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Medical Compression Stockings	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Other: _____	<input type="checkbox"/> R <input type="checkbox"/> L

484.5 Varicose veins with compl. (pain edema swelling)

729.5 Pain in leg

782.3 Edema in leg

FOLLOW-UP APPOINTMENT DATE: _____

TIME: _____

How Many