UVA Radiology Vein and Vascular Care

Vascular Screening Form

1. Do you experience any of the following?
   - Aching/pain in your legs? Yes No
   - Heaviness Yes No
   - Tiredness/fatigue Yes No
   - Itching/burning Yes No
   - Swollen ankles Yes No
   - Leg cramps Yes No
   - Restless legs Yes No
   - Throbbing Yes No
   - Other ________________________

2. Have your veins become worse in recent months? Yes No

3. Do you have any problem walking? Yes No
   If yes, how does it affect you? ______________________________________

4. Do you stand much at work or home? Yes No

5. How does standing affect your legs? ________________________________

6. Do you elevate your legs to relieve discomfort? Yes No

7. Do you wear support hose prescribed by a doctor? Yes No
   If yes, how long have you worn them? ________________________________
   If yes, do they provide relief? ______________________________________

8. Do you wear light support hose (e.g. Sheer energy?) Yes No
   If yes, do they provide relief? Yes No

9. Have you ever had your veins evaluated before? Yes No
   If yes, when and where? ___________________________________________

10. Have you ever had any test done on your veins? Yes No

11. Have you ever had vein-stripping surgery? Yes No
    If yes, which leg and when? ______________________________________

12. Have you ever had vein injections? Yes No
    If yes, when, where, and which leg? ________________________________

13. Does anyone in your family have varicose veins, spider veins, leg ulcers or swollen legs? Yes
    If yes, who? ___________________________________________________

14. Have you ever had a blood clot (Deep vein thrombosis) in leg? Yes No
    If so, which leg and when? ________________________________________

15. Have you ever had phlebitis (inflammation of vein)? Yes No
    If so when and which leg? _________________________________________

16. Have you every had difficult to heal wounds on your legs? Yes No