



Venous Screening Program

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Date: _____ Age: _____ SEX: Male / Female Your home ZIP code _____

Height: Feet _____ Inches _____ Weight in pounds: _____

Race: Caucasian / African-American / Asian / Hispanic / Native American / Other

What specialty is your personal doctor or primary care physician? (Circle one)

Internist / Family practitioner / Cardiologist / Clinic doctor / HMO doctor

Osteopath / Other / I don't have a doctor

Do you have? Diabetes Y/N High blood Pressure Y/N Heart failure Y/N Smoker? Never / Now / Quit

Do you take blood thinner? None / Coumadin / Aspirin / Plavix / Ticlid / Pletal / Aggrenox

Why are you here today? (circle most appropriate):

Do you have leg pain? (None) (Occasional) (Daily) (Limit activities)

Do you have swelling? (None) (Evenings/ankle only) (Afternoon/leg) (Morning/leg)

Do you use compression stockings? (Not used) (Intermittent use) (Most days) (Continually)

Medical History (Circle appropriate answers)

Points

- | | | | |
|---|-----|----|-------|
| 1. Have you ever had a blood clot in your legs or lungs? | Yes | No | (3) |
| 2. Do you have a family history of blood clots in the veins? | Yes | No | (3) |
| 3. Do you have leg swelling every day? | Yes | No | (1) |
| 4. Do you have visible varicose veins or spider veins? | Yes | No | (1) |
| 5. Do you have inflammatory bowel disease? | Yes | No | (1) |
| 6. Do you have emphysema or COPD? | Yes | No | (1) |
| 7. Have you had more than three days of continuous bed rest due to injury or illness in past month? | Yes | No | (1) |
| 8. Have you had a pelvic fracture or a plaster leg cast in the last month? | Yes | No | (1) |
| 9. Have you had a stroke, heart attack, or heart failure? | Yes | No | (1) |
| 10. Have you had major surgery lasting over an hour in the last month? | Yes | No | (1) |
| 11. Do you have or have you had a malignant disease (cancer)? | Yes | No | (1) |
| 12. Do you weigh over 250 pounds? | Yes | No | (1) |
| 13. AGE (Circle) Under 40 40-59 (1) 60-69 (2) Over 70 (3) | | | _____ |

The following questions are for WOMEN only

- | | | | |
|---|-----|----|-----|
| 14. Do you use birth control pills or estrogen replacement therapy? | Yes | No | (1) |
| 15. Are you pregnant or had a baby within the last month? | Yes | No | (1) |

Total: _____