'Ohana CARDIOLOGY

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VASCULAR SCREENING ASSESSMENT TOOL

RISK FACTORS *Check all that apply.*

- ❒ Diabetes Type 1 or 2
- ❒ Smoking/Tobacco Use in past/present?
- ❒ History of Heart Disease/Stroke?
- ❒ Stents in heart or legs
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Kidney/Renal Disease
- ❒ Peripheral Arterial Disease
- ❒ Peripheral Vascular Disease
- ❒ May-Thurner Syndrome
- ❒ Personal history of: ❒Spider Veins ❒Varicose Veins ❒Vein Bleeds
- ❒ Family history of: ❒Spider Veins ❒Varicose Veins ❒Both
- ❒ Personal History of Blood clots in: ❒Legs ❒Lungs ❒Both
- ❒ Family history of Blood Clots in: ❒Legs ❒Lungs ❒Both

SIGNS AND SYMPTOMS: *Please circle, check and/or explain below.*

1. Do you have or have you had any of the following on your legs/feet: ❒**Open Wounds** ❒**Non-healing Wounds** ❒**Sores** ❒**Trauma** (falls, broken bones, hitting/banging onto something hard.)
2. Do you have or had any skin discoloration below the knee or any skin blistering when swelling occurs? ❒**Yes** ❒**No**
3. Have your symptoms altered your daily life activities? **Example: (Unable to stand/sit for long period of time which inhibits driving, work duties, shopping, exercise, etc.)**

   _____

   _____
4. Do you experience any hip, buttocks, leg or thigh pain/achiness/burning/throbbing/cramping while walking or exercising causing you to stop and rest? **(Please circle all that apply.)**
5. While laying down or sleeping do you experience any of the following in Legs/Feet: ❒**Restlessness** ❒**Numbness/Tingling** ❒**Pain**
6. Please indicate what methods you have used to alleviate leg discomfort: ❒**Leg Elevation** ❒**Exercise** ❒**OTC Pain Medications** (Tylenol, Ibuprofen, Aleve, topical creams like Aspercreme, Icy Hot, etc.) **Taking for how long?** _____
7. Do you own or have been prescribed medical grade compression stockings? ❒**Yes** ❒**No**
   a. If so, please provide month/year you started wearing? _____
   b. How long do you wear them? ❒**Never** ❒**Some of the time** ❒**All of the time**
   c. When do you wear them? ❒**Day** ❒**Evening** ❒**While Sleeping**
   **** Most Insurances mandate a minimum of 3 months of consistent wearing prior to approval of any vein treatment****
8. Do you experience: ❒**Cold Legs** ❒**Cold Feet** ❒**Cold toes while other areas of your body are warm?** _____
9. Have you ever had any testing and or procedures done on your legs? If so, where and when?

   _____

   _____
10. Are you currently under the care of a Podiatrist? If so, name and office phone:

    _____
11. Are you currently under the care of a Nephrologist? (Kidney doctor) If so, name and office phone:

    _____
12. Are you on or have you been prescribed a diuretic (water pill) medication for swelling of lower extremities? ❒**Yes** ❒**No**
13. Are you currently on any hormone medications? ❒Yes ❒No If so, please list:

    _____

    _____
14. Females Only: ❒Currently Pregnant ❒# of pregnancies _____ ❒Breastfeeding ❒Pelvic Pain ❒Varicose veins of groin, vulva or labia

Patient Name: *(Please Print)* _____ **Date of Birth:** _____

PATIENT SIGNATURE: *(Please Print)* _____ **Date:** _____