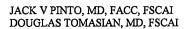
Patient Self-Assessment





PATIENT SELF-ASSESSMENT

Please take this self-assessment to see if you might be a candidate for addition	onal screeni	ng for potent	ial
varicose veins and / or chronic venous insufficiency.			
History			
Have you ever had varicose veins?	O Yes	O No	
Signs and Symptoms			
Do you experience any of the following signs and symptoms in your legs or a	nkles?		
Do you experience leg pain, aching or cramping?	O Yes	O No	
Do you experience leg or ankle swelling, especially at the end of the day?	O Yes	O No	
Do you feel "heaviness" in your legs?	O Yes	O No	
Do you experience restless legs?	O Yes	O No	
Do you have skin discoloration or texture changes?	O Yes	O No	
Do you have open wounds or sores?	O Yes	O 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?	O Yes	O No	
Have you had any treatments of procedures for vein problems?	O Yes	O No	
Do you stand for long periods of time, such as at work?	O Yes	O No	
<u>Self-Assessment Results</u> If you answered yes to one or more of the above questions, please contact u you may be candidate for venous reflux disease.	s for a consi	ultation to se	e if
Name:			
Contact number:			