Citrin Cardiology, P.C.

Vein and Vascular Assessment

Patient Name:_____Date:_____

1. Do you experience pain, aching, pressure, burning or discomfort in your legs or ankles? (circle symptoms that apply) **YES NO**
2. Do you experience cramping/tightening in your legs? **YES NO**
3. Do you have Varicose Veins that cause discomfort? **YES NO**
4. Do you experience swelling in your legs or ankles? **YES NO**
5. Do your legs feel restless? **YES NO**
6. Do your symptoms get worse when you stand or sit? **YES NO**
7. Have you experienced any ulcers, wounds or sores? **YES NO**
8. Have you experienced discoloration/darkening of the skin on your legs, ankles or feet? **YES NO**
9. Do you wear or have your worn any compression hose in the past? **YES NO**
10. Have you ever been treated or seen by another doctor for your veins? **YES NO**

    If so, when was your last appointment?_____ Procedure?_____
11. Have you ever been told you have venous insufficiency? **YES NO**
12. Do these symptoms affect your daily life/work/sleep? **YES NO**

Patient Signature:_____

Clinical use only:

Positive:_____ Negative:_____

Notes:_____