



# HACKENSACK VEIN CENTER

*Dr. Angel J Mulkay  
Dr. Scott D Ruffo*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## ***Patient Screening Questionnaire***

- |  |          |          |
|--|----------|----------|
| <b><i>1. Do you suffer from pain in your legs?</i></b>                                   | <b>Y</b> | <b>N</b> |
| <b><i>2. Do you suffer from burning or cramping in your legs?</i></b>                    | <b>Y</b> | <b>N</b> |
| <b><i>3. Do you suffer from swelling in your lower legs?</i></b>                         | <b>Y</b> | <b>N</b> |
| <b><i>4. Do you suffer from leg ulcers or chronic wounds?</i></b>                        | <b>Y</b> | <b>N</b> |
| <b><i>5. Do you have varicose or spider veins?</i></b>                                   | <b>Y</b> | <b>N</b> |
| <b><i>6. Do you suffer from restless legs?</i></b>                                       | <b>Y</b> | <b>N</b> |
| <b><i>7. Have you ever have phlebitis or cellulitis of your lower legs?</i></b>          | <b>Y</b> | <b>N</b> |
| <b><i>8. Have you ever had blood clots in your legs?</i></b>                             | <b>Y</b> | <b>N</b> |
| <b><i>9. Have you ever had previous vein treatment?</i></b>                              | <b>Y</b> | <b>N</b> |
| <b><i>9a. What type: Laser      Surgery      Sclerotherapy      Phlebectomy</i></b>      |          |          |
| <b><i>9b. When: _____</i></b>  |          |          |
| <b><i>10. Have you ever used support hose / stockings for greater than 6 months?</i></b> | <b>Y</b> | <b>N</b> |
| <b><i>11. Have you used anti- inflammatory medications &gt; 6 months?</i></b>            | <b>Y</b> | <b>N</b> |

***Patient Signature: \_\_\_\_\_***

***Thank you***

***Hackensack Vein Center***



***Don't Run From Your Legs!***