Vein Questionnaire

Patient Name:_____

Date of Birth: _____/_____/_____ *(MM/DD/YYYY)*

Today's Date: _____/_____/_____ *(MM/DD/YYYY)*

For Office Use Only:

B/P: **P:**

**** PLEASE READ****

PLEASE TAKE TIME TO FILL OUT THIS FORM IN ITS' ENTIRETY. THIS FORM WILL BE USED WHEN COMMUNICATING YOUR SYMPTOMS AND TYPES OF CONSERVATIVE TREATMENT(S) USED TO DATE WITH YOUR INSURANCE CARRIER. MOST INSURANCE CARRIERS HAVE CERTAIN CRITERIA THAT NEEDS TO BE MET BEFORE THEY AUTHORIZE ANY TYPE OF TREATMENT. CONSERVATIVE TREATMENTS USED TO RELIEVE SYMPTOMS INCLUDE SUPPORT STOCKINGS, PAIN MEDICATIONS, EXERCISE, LEG ELEVATION, WALKING, ETC.

Refferal Information

How did you hear about us?

☐ Mail Inserts ☐ TV *What Channel?* _____ ☐ Patient Refferal/Word of Mouth: _____

☐ Internet ☐ Magazines

☐ Other_____ ☐ Physician Refferal_____

Primary Care Information

Primary Care Physician:_____ Phone Number:_____

Venous Symptoms

Which Leg?: ☐ **Both** ☐ **Right** ☐ **Left**

Do your legs or ankles……. **……..If so, please describe as thorogh as possible:**

☐ Yes ☐ No Ache or Hurt?_____

☐ Yes ☐ No Swell? _____

☐ Yes ☐ No Cramp? _____

☐ Yes ☐ No Become Restless? _____

☐ Yes ☐ No Become tired/heavy?_____

☐ Yes ☐ No Itch? _____

☐ Yes ☐ No Burn? _____

Associated with:

☐ Varicose Veins ☐ Purple vein network

☐ Skin discoloration below the knees ☐ Abdominal Veins

☐ Spider Veins ☐ Bulging Veins

☐ Ankle Sores ☐ Diagnosis of venous insufficiency

How long have you had these symptoms?_____ _____

Are your symptoms getting worse? ☐ Yes ☐ No

Overall, how much of an impact do your symptoms have on your daily living activities?

Please circle one of the following: (None) 0 1 2 3 4 5 (Severe)

Please check all types of conservative treatment(s) you have used to date to relieve your leg discomfort:

☐ Compression Stockings If so, how long?_____ ☐ Wraps

☐ Aspirin/Tylenol/Ibuprofen/Pain meds. ☐ Exercise

☐ Leg Elevation ☐ Walking

Relevant History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

☐ Yes ☐ No	Phlebitis *(inflammation or infection of the veins)*	When?	_____
☐ Yes ☐ No	Leg clots or deep vein thrombosis *(DVT)*	When?	_____
☐ Yes ☐ No	Lung clots or pulmonary embolism *(PE)*	When?	_____
☐ Yes ☐ No	Heart, Liver or Kidney problems	When?	_____
☐ Yes ☐ No	Cancer What type*?* _____	When?	_____
☐ Yes ☐ No	Bleeding or clotting abnormalities	When?	_____
☐ Yes ☐ No	Lupus/scleroderma/ rheumatoid arthritis	When?	_____
☐ Yes ☐ No	HIV/AIDS/Hepatitis B or C	When?	_____
☐ Yes ☐ No	PAD (Peripheral Artery Disease)	When?	_____

Have you had any of the following experiences? (check all that apply)

☐ Yes ☐ No	Leg swelling after a long airplane or car trip? *When?*		_____
☐ Yes ☐ No	Leg Trauma *(including surgery)*	*When?*	_____

Are you on your feet for long periods of time? ☐ Yes ☐ No

In what capacity?_____

Does walking/exercising relieve you from discomfort or make it worse? ☐ Relieves ☐ Worsens

Have you been treated for you vein before? ☐ Yes ☐ No

By Whom? _____ When?_____

What Method?

- ☐ Injections
- ☐ Stripping
- ☐ Ambulatory Phlebectomy
- ☐ Ligation
- ☐ Ultrasound-guided injections
- ☐ Radiofrequency closure
- ☐ Laser closure
- ☐ Laser for spider veins

What have your results been? _____

What would you like to correct about your legs? _____

_____

Habits

Alcoholic Beverages ☐ Yes ☐ No If so, please inform how many _____ per week

Exercise: ☐ Regular ☐ 1-3 times per week ☐ Seldom ☐ Never

Tobacco Use: ☐ Yes- quantity: _____ ☐ Previously Smoked- Quit Date: _____ ☐ No

Illicit Drug Use: ☐ Yes ☐ No If so, list type of drug: _____

Medical History *(i.e., high blood pressure, high cholesterol, diabetes, heart disease, etc.)*

_____

_____

_____

Surgical History

Have you ever had surgery? ☐ **Yes** ☐ **No** **If yes, please explain below:**

Please list all medical surgeries *(including dates)* _____

_____

_____

_____

Family History

☐ Venous Insufficiency ☐ Varicose Veins/Spider Veins ☐ Venous Ulcers

Do you have allergies? ☐ **Yes** ☐ **No** **If yes please explain:**_____

☐ Penicillin ☐ Antibiotics ☐ Vicryl
☐ Lidocaine ☐ Sulfa ☐ Latex
☐ Cosmetic Products_____ ☐ Seasonal Allergies ☐ Other:_____

Are you taking any of the following? ☐ **Yes** ☐ **No**

☐ Blood Thinners ☐ Hydroquinone ☐ Vitamin E
☐ NSAIDs (Advil, Aleve, Naprosyn) ☐ Antibiotics (oral or topical) ☐ St. John's Wart
☐ Retin A ☐ Antivirals ☐ Gold Therapy
☐ Accutane ☐ Topical Steroids

Current Medications

Medications	Dosage	Frequency	Reason for taking each medication:

_____ _____
Patient Signature: Date:

Physician Section (Do NOT fill out below; For physician use only)

Treatment Plan:

Venous Ultrasound ☐ **Start/Continue Compression Stockings** ☐
Return with results ☐ **Cosmetic Sclerotherapy** ☐

_____ _____
Physician's Signature: Date: