Vein Questionnaire

Patient Name:_____
Date of Birth: _____/_____/_____ *(MM/DD/YYYY)*
Today's Date: _____/_____/_____ *(MM/DD/YYYY)*

For Office Use Only:

RT	**B/P:**	**P:**
LT	**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.

Referral Information

How did you hear about us?

☐ Mail Inserts ☐ TV *What Channel?* _____ ☐ Patient Referral/Word of Mouth: _____
☐ Internet ☐ Magazines
☐ Other_____ ☐ Physician Referral_____

Primary Care Information

Primary Care Physician:_____ Phone Number:_____

Leg Symptoms

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

Do you have any of the following:

☐ Varicose Veins
☐ Skin discoloration below the knees
☐ Spider Veins
☐ Ankle Ulcers/ Open Sores
☐ Bleeding Veins
☐ Purple vein network
☐ Abdominal Veins
☐ Bulging Veins
☐ Known diagnosis of vein problems
☐ Stasis Dermatis/ Rash around ankles

Do you experience any of these symptoms on your leg or ankles…….. Please circle any of the following

Ache or Hurt Throbbing Cramping Restlessness Numbness

Tiredness/ Heaviness Swelling Itching Burning

How long have you had these symptoms?_____ _____

Are your symptoms getting worse? ☐ Yes ☐ No

Since your symptoms vary day to day. Please choose your level of severity when they are **at their worst.**

(mild) 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?_____
☐ Aspirin/Tylenol/Ibuprofen/Pain meds.
☐ Leg Elevation
☐ Wraps
☐ Exercise
☐ 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?	
☐ Yes ☐ No	Migraines with Aura	When?	
☐ Yes ☐ No	Moderate to severe asthma	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 your veins before? ☐ Yes ☐ No

By Whom?_____ When?_____

What Method?

- ☐ Injections
- ☐ Stripping
- ☐ Ambulatory Phlebectomy
- ☐ Ligation
- ☐ Ultrasound-guided injections
- ☐ Radiofrequency closure
- ☐ Laser closure (Endovenous/Catheter Based)
- ☐ Laser for spider veins

What have your results been? _____

_____

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: _____

List any health problems *(examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)*

_____

_____

_____

Surgical History

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

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

_____

_____

For Women Only- Pregnancy History:

Number of Births: _____ Number of Miscarriages: _____

Family History

☐ Deep Venous Thrombosis (DVT) ☐ Pulmonary Embolism (PE) ☐ Leg Swelling ☐ Venous Ulcers ☐ Varicose/ Spider Veins

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

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

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

☐ Blood Thinners ☐ Hydroquinone ☐ Vitamin E
☐ NSAIDs (Advil, Aleve, Naprosyn) ☐ Minocyline ☐ St. John's Wort
☐ Retin A ☐ Antivirals ☐ Gold Therapy
☐ Accutane ☐ Topical Steroids ☐ Iron Supplements

Current Medications

Medications	Dosage	Frequency	Reason for taking each medication:

Patient Signature: Date:

PHYSICIAN SECTION ONLY (Do NOT fill out below; For physician use only)

History of Present Illness:

_____
_____
_____
_____
_____
_____
_____

Review of Symptoms:

_____
_____
_____
_____

Physical Exam:

_____
_____
_____
_____

Assessment:

_____
_____
_____
_____

Treatment Plan:

Venous Ultrasound	☐	**Start/Continue Compression Stockings**	☐
Return with results	☐	**Cosmetic Sclerotherapy**	☐
		Lower Extremity Venogram/ MRV	☐

_____
_____

Physician's Signature: _____ Date: _____