

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	☐ Purple vein network
☐ Skin discoloration below the knees	☐ Abdominal Veins
☐ Spider Veins	☐ Bulging Veins
☐ Ankle Ulcers/ Open Sores	☐ Known diagnosis of vein problems
☐ Bleeding Veins	☐ 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? _____	☐ 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 (<i>inflammation or infection of the veins</i>) | When? _____ |
| ☐ Yes | ☐ No | Leg clots or deep vein thrombosis (<i>DVT</i>) | When? _____ |
| ☐ Yes | ☐ No | Lung clots or pulmonary embolism (<i>PE</i>) | 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 (<i>including surgery</i>) 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 | ☐ Ultrasound-guided injections |
| ☐ Stripping | ☐ Radiofrequency closure |
| ☐ Ambulatory Phlebectomy | ☐ Laser closure (Endovenous/Catheter Based) |
| ☐ Ligation | ☐ 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)

☐ Minocycline

☐ 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 ☐
Return with results ☐

Start/Continue Compression Stockings ☐
Cosmetic Sclerotherapy ☐
Lower Extremity Venogram/ MRV ☐

Physician's Signature:

Date:

