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.

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:________________________________

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 you 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 you vein 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.)*

____

____

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Surgical History

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

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

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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

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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:

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Review of Symptoms:

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Physical Exam:

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Assessment:

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Treatment Plan:

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

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_______________________________________ Physician's Signature:

_______________ Date:

FOR PHYSICIAN USE ONLY

CEAP Classification:

To determine the CEAP classification, please indicate the appropriate responses in each of the classifications below

Level of Examination:

☐ Level I	☐ Level II	☐ Level III
office visit, with history and clinical examination, which may include use of hand held Doppler scanner	noninvasive vascular laboratory testing, which routinely includes duplex color scanning, with some plethysmographic method added as desired	invasive and more complex imaging studies, including venography, venous pressure measurements, CT, venous helical sanning or MRI

Clinical Classification

- ☐ No visible or palpable signs of venous disease
- ☐ Varicose veins (>3mm)
- ☐ Pigmentation or Eczema
- ☐ Healed Venous Ulcer
- ☐ Symptomatic
- ☐ Telangiectasis or Reticular vein (<3mm)
- ☐ Edema
- ☐ Lipodermatosclerosis or Atrohpie Blanche
- ☐ Active Venous Ulcer
- ☐ Asymptomatic

Etiology:

- ☐ Congenital
- ☐ Primary
- ☐ Secondary (Post-thrombotic)
- ☐ No venous cause identified

Anatomy:

- ☐ Superficial veins
- ☐ Perforator veins
- ☐ Deep veins
- ☐ No location identified

Pathophysiology:

- ☐ Reflux
- ☐ Obstruction
- ☐ Reflux and Obstruction
- ☐ No Psthophysiology Identifiable

Venous Insufficiency:

- ☐ Grade 1
- ☐ Grade 2
- ☐ Grade 3
- ☐ Grade 4
- ☐ Grade 5

Venous Clinical Severity Score statement:

Varicose Veins	Edema	Pigmentation	Pain	Inflammation
☐ None	☐ None	☐ None	☐ None	☐ None
☐ Few	☐ Evening	☐ Limited+Old	☐ Occasional	☐ Mild
☐ Multiple	☐ Afternoon	☐ Diffuse	☐ Daily	☐ Moderate
☐ Extensive	☐ Morning	☐ Wider Dist	☐ Limiting	☐ Severe

Induration	Active Ulcers	Duration of AU's	Diameter	Compression Used
☐ None	☐ None	☐ None	☐ None	☐ None
☐ < 5cm	☐ 1	☐ < 3 m	☐ < 2 cm	☐ Occasional
☐ < lower 1/3	☐ 2	☐ 3 m - 1 y	☐ 2 - 6 cm	☐ Multiple
☐ Entire Lower	☐ 3 or > 3	☐ > 1 y	☐ > 6 cm	☐ Extensive