

# THE VENOUS INSTITUTE OF BUFFALO

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*Patient Venous History*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**\*\*Your insurance carrier (including Medicare) may require a minimum of at least 3-6 months of "conservative, non-operative treatment" in order for them to pre-approve/make payment for your services. The insurance carriers define "conservative, non-operative treatment" to include: "Mild exercise, periodic leg elevation, weight loss, compressive therapy (stockings), and avoidance of prolonged inactivity". Please take your time to fill out this questionnaire. \*\***

Please circle YES or NO

1. Have you had any prior treatment for varicose/spider veins? **YES NO**

Describe \_\_\_\_\_ Date (s) of treatment \_\_\_\_\_ Surgery Dates \_\_\_\_\_

Type of agent (s) used, if known \_\_\_\_\_

2. Do you have a history of ulcerations, chronic swelling of your legs, or blood clots? **YES NO** When? \_\_\_\_\_

3. Do you have a family history of varicose/spider veins/ulcers? **YES NO** If yes, relationship (s) to you \_\_\_\_\_

4. Are you currently, or have been, on any hormone therapy or birth control pills? **YES NO**

If yes, please list \_\_\_\_\_

5. Have you had any pregnancies? **YES NO** If yes, how many children do you have? \_\_\_\_\_

If yes, did your varicose/spider veins increase after your pregnancy? **YES NO**

6. Have you worn prescription stockings/hose? **YES NO** \_\_\_ #months worn \_\_\_ #years worn

7. Are you presently employed? **YES NO** If yes, type of job \_\_\_\_\_

8. Do you sit or stand for long periods of time? **YES NO** Hours per day? Sitting \_\_\_ hours Standing \_\_\_ hours

9. **\*\*Please describe how your condition/discomfort LIMITS/IMPACTS your daily activity?" Frequency/ timing of discomfort/pain?**

10. Have you taken any pain medication for you varicose/spider veins? **YES NO** \_\_\_ # months \_\_\_ #years

(Including Aspirin, Tylenol, Motrin IB, Advil, etc.) If yes, please list \_\_\_\_\_

11. Do you elevate your legs to relieve your symptoms? **YES NO** \_\_\_ hours/day , # months \_\_\_, # years \_\_\_

If yes, does it help? \_\_\_\_\_

12. Are you presently on a weight loss/weight management routine? **YES NO** \_\_\_ # months

13. Do you exercise? **YES NO** Mild/Occasional  Regular Regiment  Intense workout # months \_\_\_\_\_

14. Have you had any severe leg injury or major leg surgery? **YES NO** If yes, describe

## **PLEASE CHECK ALL THAT APPLY:**

	<b>RIGHT LEG</b>	<b>LEFT LEG</b>
Tire		
Edema (Swelling)		
Pain (Mild, Moderate, & Severe)		
Tiredness, Throbbing, Achiness		
Ulceration		
Skin Color Changes		
Spider Veins		
Varicose Veins		
Vein ruptured (bleeding)		

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_