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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:

Table with 3 columns: Symptom, RIGHT LEG, LEFT LEG. Rows include Edema (Swelling), Pain (Mild, Moderate, & Severe), Tiredness, Throbbing, Achiness, Ulceration, Skin Color Changes, Spider Veins, Varicose Veins, Vein ruptured (bleeding).

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