Alaska Vein Clinic Medical Questionnaire

Thank you for visiting the Alaska Vein Clinic. Please answer all the questions the best you can. If you are not sure how to answer any question just write a question mark next to the item.

(▶Indicates important item with regards to insurance coverage & authorization)

Name: ____ Date _____/_____/_____

Age:______ Date of Birth: _____/_____/_____

I was referred by: ☐Physician ☐Other Health Care Provider ☐Friend ☐Self

Name (if applicable): ____

☐Web Search ☐TV Ad ☐Radio Ad ☐I have been seen here before.

I am here for:	Both legs	Right Leg	Left Leg
Varicose veins:			
Lymphedema:			
Pain of uncertain cause:			
Swelling of uncertain cause:			

☐I am here for reasons other than varicose veins (elaborate below)

>>**IMPORTANT!! In your own words briefly describe how your varicose veins or other issues significantly affect the quality of your life. This is often used by insurance companies to determine whether or not they will cover the procedure!**

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Signs and Symptoms	Both legs	Right Leg	Left Leg
Aches and Pains:			
Heaviness and Tiredness:			
Swelling:			
Night Cramps:			
Bleeding from Veins:			
Itching:			
Burning:			
Pigmentation (Discoloration):			
Hardening and Thickening of the Skin:			
Open Sores / Skin Ulcers:			

▶ **My symptoms:**	Yes	No
are made worse by prolonged standing:		
are worse at the end of the day:		
interfere with exercising or physical activity:		
interfere with my job function:		
are helped with elevation:		
are helped with exercise:		

▶ I frequently use pain medication because of my varicose veins: ☐Yes ☐No

Name of pain medication: ____

▶ I have had varicose veins for ________ years.

Name:________________________________

Support Stocking Use:

I routinely wear prescription support stockings: ☐Yes ☐No

If yes, how long have you been wearing them? ____________________________

I do not wear or have stopped wearing support stockings for the following reasons:

☐They have never been prescribed.

☐They are too uncomfortable.

☐Other: ____

Prior Vein Problems: ☐**no vein problems**	Yes	No
Superficial thrombophlebitis (clot in surface vein):		
Deep vein thrombosis:		
Pulmonary Embolisms (blood clot to lung):		
Hypercoagulable state (tendency to clot):		

Prior Vein Treatment: ☐**no prior vein treatment**	Yes	No
Laser ablation:		
Radiofrequency Ablation:		
Saphenous vein stripping:		
Local excision of varicose veins:		
Sclerotherapy:		

☐Other / Describe / Elaborate Items above:

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Name:____

General Medical History:

Past Operations: ☐ No prior operations

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Medical Problems: ☐ No medical problems

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Allergies: ☐ No Allergies

Medicine or Agent	Type of reaction:	Mild / Mod / Severe

Current Medications: ☐ No Medications

Medicine:	Dose:	Frequency:	Route:

Comments:____

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Name:______________________________

Social History:

Do you smoke? □Yes □No How long? ___________ How many packs a day? _______

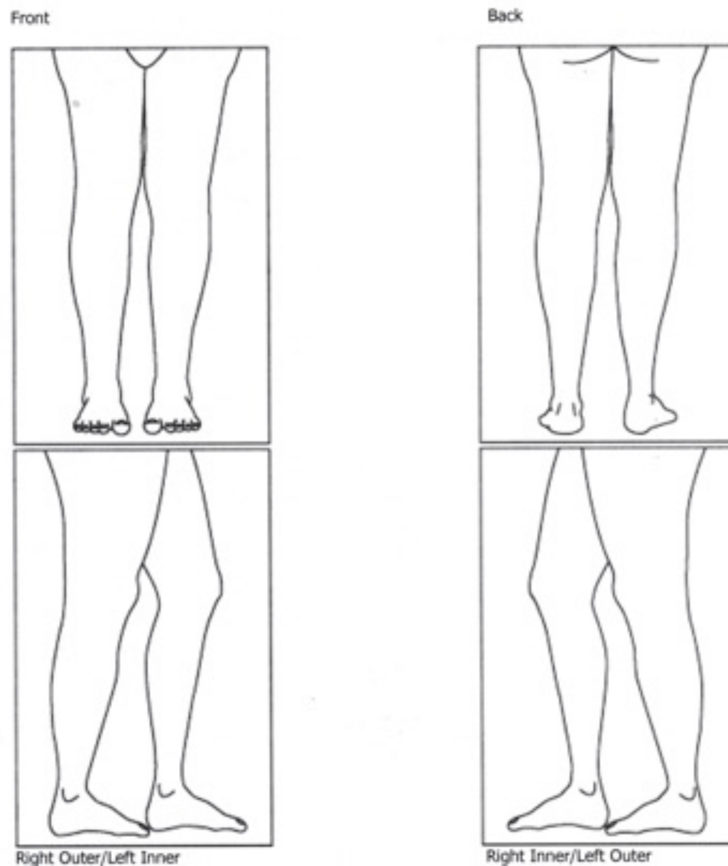
Do you drink alcohol? □Yes □No How much? ___________________________________

Occupation? ____

Is there a family history of Varicose Veins? □Yes □No

Describe: ____

Please mark the areas where you have vein problem:



Comments: ____

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Name:_______________________________________