



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: _____ Sex: _____

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! Insurance companies determine often determine coverage by the degree of symptoms and how they affect the quality of your life, ability to perform at your job or duties at home.

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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.

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: <input type="checkbox"/> 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: <input type="checkbox"/> no prior vein treatment	Yes	No
Laser ablation:		
Radiofrequency Ablation:		
Saphenous vein stripping:		
Local excision of varicose veins:		
Sclerotherapy:		

Other / Describe / Elaborate Items above:

General Medical History:

Past Operations: No prior operations_

Medical Problems: No medical problems

Allergies: No Allergies

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

Current Medications: No Medications

Medicine:	Dose:	Frequency:	Route:

Comments: _____

Social History:

Do you smoke? Yes No How long? _____ How many packs a day? _____

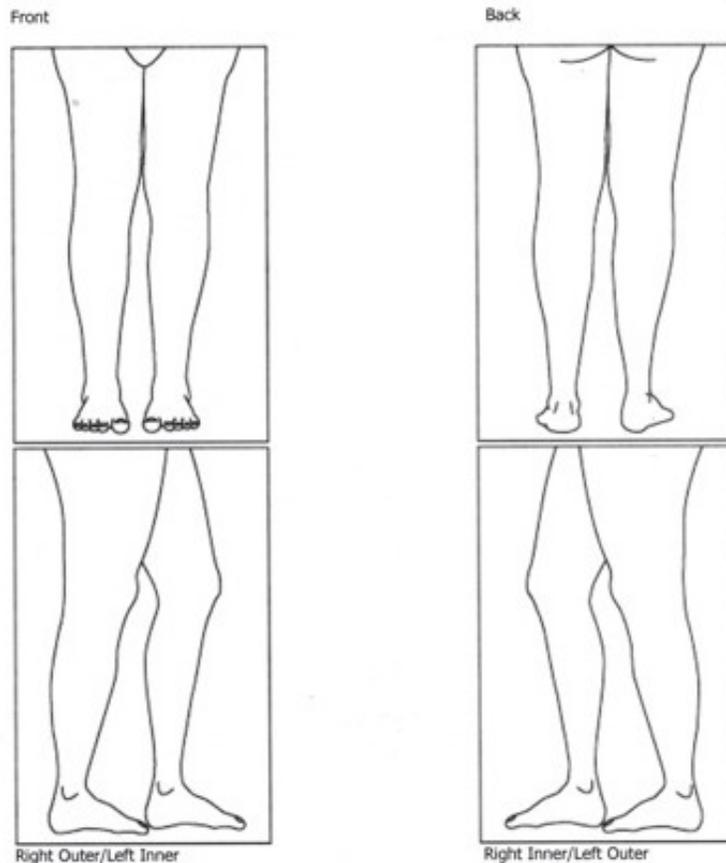
Do you drink alcohol? Yes No How much? _____

Occupation? _____

Is there a family history of Varicose Veins? Yes No

Describe: _____

Please mark the areas where you have vein problem:



Comments: _____

