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 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. Please describe how your symptoms affect the quality of your life.

_____

_____

_____

_____

▶ How long have you suffered from varicose veins? _____ ☐Not sure

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:		

▶ **<u>Important!</u> Many insurance companies require the previous use of pain medications when making a determination of providing benefit:**

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

Name of pain medication: _____

Dates of use: _____

▶ **Important!** **Many insurance companies require the previous use of support stockings for at least 3 months when making a determination of providing benefit:**

▶ **Support Stocking Use:**

I routinely currently wear or have worn support stockings: ☐Yes ☐No

Approximate dates of use: _____

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:

_____

_____

_____

_____

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? _____

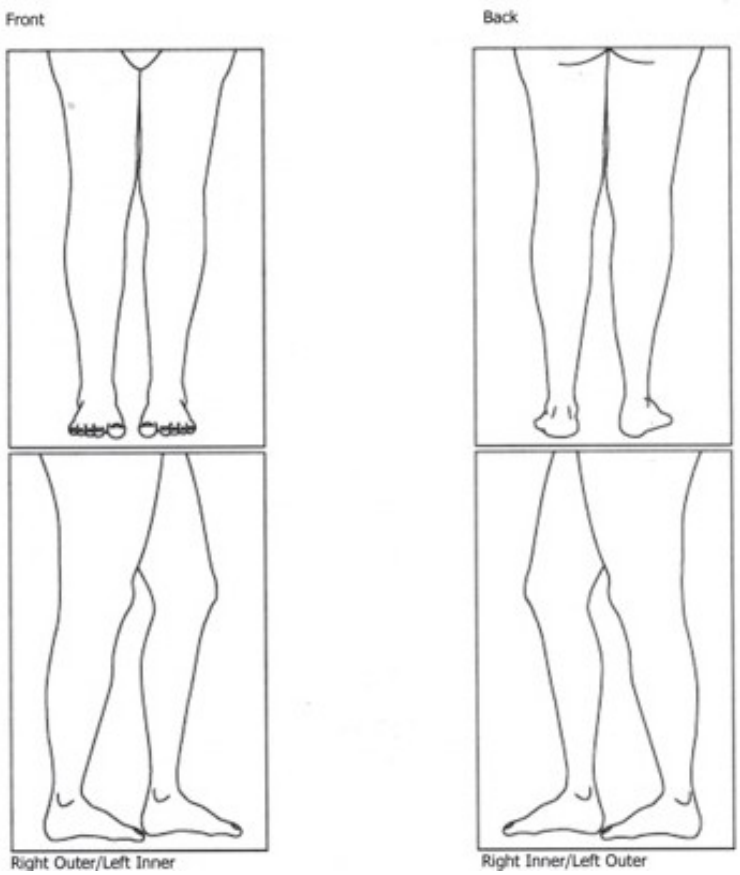
Do you drink alcohol? □Yes □No How much? _____

Occupation? _____

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

Describe: _____

Please mark the areas where you have vein problem:



Comments: _____

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