## Vein Questionnaire

| Patient Name:   |   |   |              |
|-----------------|---|---|--------------|
| Date of Birth:  | / | / | (MM/DD/YYYY) |
| Today's Date: _ | / | / | (MM/DD/YYYY) |



|    | For Office | Use Only: |
|----|------------|-----------|
| RT | B/P:       | Ρ:        |
| LT | B/P:       | Ρ:        |

## **\*\* PLEASE READ\*\***

PLEASE TAKE TIME TO FILL OUT THIS FORM IN ITS' ENTIRETY. THIS FORM WILL BE USED WHEN COMMUNICATING YOUR SYMPTOMS AND TYPES OF CONSERVATIVE TREATMENT(S) USED TO DATE WITH YOUR INSURANCE CARRIER. MOST INSURANCE CARRIERS HAVE CERTAIN CRITERIA THAT NEEDS TO BE MET BEFORE THEY AUTHORIZE ANY TYPE OF TREATMENT. CONSERVATIVE TREATMENTS USED TO RELIEVE SYMPTOMS INCLUDE SUPPORT STOCKINGS, PAIN MEDICATIONS, EXERCISE, LEG ELEVATION, WALKING, ETC.

|                    | Patient Re   | ferral/Word of Mouth:  |
|--------------------|--|--|
|                    |  |  |
| Phy                | /sician Referral                                   |  |
|                    |  |  |
|                    | Phone Number:                                      |  |
|                    |  |  |
| Both               | 🗌 Right  | 🗆 Left   |
|                    |  |  |
|                    | Purple vein network                                |  |
|                    | Abdominal Veins                                    |  |
|                    | Bulging Veins                                      |  |
|                    | Known diagnosis of version                         | ein problems   |
|                    | Stasis Dermatis/ Rash                              | around ankles  |
| your leg or ankle  | s Please circle any of t                           | the following  |
| Cramping           | Restlessness                                       | Numbness   |
| Swelling           | Itching  | Burning  |
|                    |  |  |
| 🗌 Yes              | 🗆 No   |  |
| choose your leve   | l of severity when they are                        | <u>at their worst.</u>   |
| 4 5                | (severe)   |  |
| ent(s) you have us | sed to date to relieve your                        | leg discomfort:  |
| ng?                | Wraps  |  |
| ds.                | Exercise   |  |
|                    | Walking  |  |
|                    | Phy Both Cramping SwellingYes choose your leve 4 5 | Physician Referral          Phone Number:         Phone Number:         Phone Number:         Phone Number:         Purple vein network         Abdominal Veins         Bulging Veins         Known diagnosis of veil         Stasis Dermatis/ Rash         your leg or ankles         Please circle any of the stass of the sta |

| Does walking/exercising relieve you from discomfort or make it worse? Relieves Worsens   Have you been treated for your veins before? Yes No   By Whom? When? When?   What Method? Injections Ultrasound-guided injections   Stripping Radiofrequency closure   Ambulatory Phlebectomy Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   Illicit Drug Use: Yes   Ves No   If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.) For Women Only- Pregnancy History:  | Relevant History                          |                             |                               |                          |                              |
|--|---|-----------------------------|-------------------------------|--------------------------|------------------------------|
| Yes No Leg clots or deep vein thrombosis ( <i>pvr</i> ) When?   Yes No Lung clots or pulmonary embolism ( <i>PE</i> ) When?   Yes No Cancer What pve?   Yes No Cancer What pve?   Yes No Electing or clotting abnormalities When?   Yes No Lupus/scleroderma/ rheumatoid arthritis When?   Yes No Lupus/scleroderma/ rheumatoid arthritis When?   Yes No Hiy/AlDS/Hepatits B or C When?   Yes No Hiy/AlDS/Hepatits B or C When?   Yes No Migraines with Aura When?   Yes No Migraines with Aura When?   Have you had any of the following experiences? (check all that apply)   Yes No Leg rauma (mculag surger) When?   Have you had any of the following experiences? (check all that apply)   Yes No Leg rauma (mculag surger) When?   Have you had periods of time?   Yes No Leg rauma (mculag surger) When?   Mave you vour fet for long periods of time?   Yes No Leg rauma (mculag surger) When?   Mave you had ny of the following experiences?   Yes No Leg rauma (mculag surger) When?   Mave you vour fet for long periods of time?   Yes No Leg rauma (mculag surger) When?   Mave you vour veins before?   Yes No Leg rauma (mculag surger)   What Ave your results   | Have you ever been diagnosed w            | vith any of the followin    | g conditions? (check all that | apply)                   |                              |
| Yes       No       Lung clots or pulmonary embolism (PE)       When?         Yes       No       Heart, Liver or Kidney problems       When?         Yes       No       Bleeding or clotting abnormalities       When?         Yes       No       Bleeding or clotting abnormalities       When?         Yes       No       Lups/scleroderma/ rheumatol arthritis       When?         Yes       No       HU/AIDS/Hepatits Bor C       When?         Yes       No       HU/AIDS/Hepatits Bor C       When?         Yes       No       Migraines with Aura       When?         Yes       No       Moderate to severe astima       When?         Have you had any of the following experiences? (Check all that apply)   | 🗌 Yes 🗌 No                                | Phlebitis (inflammation or  | infection of the veins)       | When?                    |                              |
| Yes       No       Heart, Liver or Kidney problems       When?         Yes       No       Cancer       When?         Yes       No       Bleeding or clotting abnormalities       When?         Yes       No       Lupus/scleroderma/ rheumatoid arthritis       When?         Yes       No       Lupus/scleroderma/ rheumatoid arthritis       When?         Yes       No       HV/AIDS/Hepatitis B or C       When?         Yes       No       Migraines with Aura       When?         Yes       No       Migraines with Aura       When?         Wes       No       Migraines with Aura       When?         Have you had any of the following experiences? (theck all that apply)  | Yes No                                    | Leg clots or deep veir      | thrombosis (DVT)              | When?                    |                              |
| Yes       No       Cancer       Whet type?       When?         Yes       No       Bleeding or clotting abnormalities       When?         Yes       No       Lupus/Scleroderma/ rheumatoid arthritis       When?         Yes       No       HW/AIDS/Hepatitis B or C       When?         Yes       No       HW/AIDS/Hepatitis B or C       When?         Yes       No       Migraines with Aura       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Moderate to severe asthma       When?         Have you had any of the following experiences? (check all that apply)       When?         Yes       No       Leg swelling after a long airplane or car trip? When?         Yes       No       Leg swelling after a long airplane or car trip? When?         Net you on your feet for long periods of time?       Yes       No         In what capacity?       Does walking/exercising relieve you from discomfort or make it worse?       Relieves       Worsens         Have you been treated for your veins before?       Yes       No       Ill when?         What Method?       Injections       Ultrasound-guided injections       Ediofrequency closure         Abubitory Phiebectomy       Laser for spider veins       Ma   | 🗌 Yes 🗌 No                                | Lung clots or pulmona       | ary embolism <i>(PE)</i>      | When?                    |                              |
| □       Yes       No       Bleeding or clotting abnormalities       When?         □       Yes       No       Lupus/scleroderma/rheumatoid arthritis       When?         □       Yes       No       PAD (Peripheral Artery Disease)       When?         □       Yes       No       PAD (Peripheral Artery Disease)       When?         □       Yes       No       Moderate to severe asthma       When?         □       Yes       No       Moderate to severe asthma       When?         □       Yes       No       Leg swelling after a long airplane or car trip? When?         □       Yes       No       Leg swelling after a long airplane or car trip? When?         □       Yes       No       Leg swelling after a long airplane or car trip? When?         □       Yes       No       Leg swelling after a long airplane or car trip? When?         □       No       Leg swelling after a long airplane or car trip? When?         □       No       Leg swelling after a long airplane or car trip? When?         □       No       Leg swelling after a long airplane or car trip? When?         □       No       Hot second secon   | 🗌 Yes 🗌 No                                | Heart, Liver or Kidney      | r problems                    | When?                    |                              |
| Yes       No       Lupus/scleroderma/ rheumatoid arthritis       When?         Yes       No       PAD (Perpiperal Artery Disease)       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Leg swelling after a long aiplane or car trip? When?         Yes       No       Leg trauma (mcluding surgeny)       When?         Are you on your feet for long periods of time?       Yes       No         In what capacity?       Does walking/exercising relieve you from discomfort or make it worse?       Relieves       Worsens         Have you been treated for your veins before?       Yes       No       By Whon?       When?         What Method?       Injections       Ultrasound-guided injections       Stripping       Radiofrequency closure         Alcoholic Beverages       Yes       No       If so, please inform how many       per week         Exercise:       Regular       1-3 times per week       Seldom       No         Ilicit Drug Use:       Yes       No       If so, please inform how many       per week         Exercise:       Regular       1-3 times  | 🗌 Yes 🗌 No                                | Cancer What type?           |                               | When?                    |                              |
| Yes       No       HiV/AIDS/Hepatitis B or C       When?         Yes       No       PAD (Peripheral Artery Disease)       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Moderate to severe asthma       When?         Yes       No       Leg swelling after a long airplane or car trip? When?         Yes       No       Leg Trauma (mctuding surgery)       When?         Are you on your feet for long periods of time?       Yes       No         In what capacity?       Does walking/exercising relieve you from discomfort or make it worse?       Relieves       Worsens         By Whom?       When?   | 🗌 Yes 🗌 No                                | 0 0                         |                               | When?                    |                              |
| Yes No PAD (Peripheral Artery Disease) When?   Yes No Migraines with Aura When?   Have you had any of the following experiences? (check all that apply) Yes No Leg swelling after a long airplane or car trip? When? Yes No Leg Swelling after a long airplane or car trip? When? Yes No Leg Swelling after a long airplane or car trip? When? When? Yes No Leg Swelling after a long airplane or car trip? When? Yes No Leg Swelling after a long airplane or car trip? When? When? Yes No Leg Trauma (including surgery) When? When? Worsens Have you been treated for your veins before? Yes No By Whon? When? When? What Method? Injections Injections Stripping Anduidrony Phlebectomy Laser closure (Endovenous/Catheter Based) Ligation Laser for spider veins What have your results been? Habits Alcoholic Beverages Yes No If so, please inform how many per week Seldom Never Tobacco Use: Yes No If so, please inform how many per week Seldom No Never Tobacco Use: Yes No If so, please inform how many per week Seldom No Never Tobacco Use: Yes No If so, please inform how many per week Seldom No Never Tobacco Use: Yes No If so, please inform how many per week Seldom No Never Tobacco Use: Yes No If so, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   | Yes No                                    | Lupus/scleroderma/ r        | heumatoid arthritis           | When?                    |                              |
| Yes No Migraines with Aura When?     Yes No Moderate to severe asthma When?   Have you had any of the following experiences? (check all that apply)      Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   Yes No Leg swelling after a long airplane or car trip? When?   Are you on your feet for long periods of time?   When? When?   When?   Does walking/exercising relieve you from discomfort or make it worse? Relieves   What Method? Ultrasound-guided injections   Stripping Radiofrequency closure   Ambulatory Philebectomy Laser for spider veins   What have your results been?   Habits </th <th>Yes No</th> <th>•</th> <th></th> <th>When?</th> <th></th> | Yes No                                    | •                           |                               | When?                    |                              |
| Yes       No       Moderate to severe asthma       When?         Have you had any of the following experiences? (check all that apply)   | 🗌 Yes 🔛 No                                | · ·                         | y Disease)                    | When?                    |                              |
| Have you had any of the following experiences? (check all that apply)  |   | -                           |                               |                          |                              |
| Yes No Leg swelling after a long airplane or car trip? When?   Yes No Leg Trauma (including surgery)   Are you on your feet for long periods of time? Yes   In what capacity? Yes   Does walking/exercising relieve you from discomfort or make it worse? Relieves   Ware you been treated for your veins before? Yes   No Injections   By Whon? When?   What Method?   Injections Ultrasound-guided injections   Stripping Radiofrequency closure   Ambulatory Phlebectomy Laser closure (Endovenous/Catheter Based)   Ligation Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages Yes   No If so, please inform how many   per week   Exercise:   Regular   1-3 times per week   Seldom   No   Illicit Drug Use:   Yes   No   If yes, please explain below:   Please list all medical surgery?   Yes   No   If yes, please explain below:   Please list all medical surgery History:   |   |                             |                               | When?                    |                              |
| Yes No Leg Trauma (including surgery) When?   Are you on your feet for long periods of time? Yes No In what capacity? Does walking/exercising relieve you from discomfort or make it worse? Relieves Worsens Have you been treated for your veins before? Yes No By Whom? What Method? What Method? Injections Stripping Arbonic for point weins before? What Method? What Method? Injections Stripping Arbonic for point weins What have your results been? Habits Alcoholic Beverages Yes No If so, list type of drug: List any health problems (examples are: arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.) For Women Only- Pregnancy History: For Women Only- Pregnancy History:   | Have you had any of the following         |                             |                               |                          |                              |
| Are you on your feet for long periods of time? Yes No   In what capacity?  |   |                             |                               | hen?                     |                              |
| In what capacity?  |   | -                           |                               | When?                    |                              |
| Does walking/exercising relieve you from discomfort or make it worse? Relieves Worsens   Have you been treated for your veins before? Yes No   By Whom? When? When?   What Method? Injections Ultrasound-guided injections   Stripping Radiofrequency closure   Ambulatory Phlebectomy Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   Illicit Drug Use: Yes   Ves No   If so, lif so, lif so, lif so, blease inform how many   per week   Exercise:   Regular   1-3 times per week   Seldom   No   If so, lif so, lif so, blease inform how many   per week   Exercise:   Regular   1-3 times per week   Seldom   No   If so, lif so, lif so, blease inform how many   Perviously Smoked-Quit Date:   No   Illicit Drug Use:   Yes   No   If yes, please explain below:   Please list all medical surgeries (including dates)   For Women Only- Pregnancy History:   |   | iods of time?               | 🔄 Yes 🔛 No                    |                          |                              |
| Have you been treated for your veins before? Yes No   By Whom? When?   What Method? Ultrasound-guided injections   By Uhom? Radiofrequency closure   Constraining Radiofrequency closure   Habits Radiofrequency closure   Alcoholic Beverages Yes   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   Exercise: Yes   Quantity: Previously Smoked- Quit Date:   No If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History Have you ever had surgery?    Have you ever had surgeries (including dotes)   For Women Only- Pregnancy History:  | In what capacity?                         |                             |                               |                          |                              |
| By Whom? When?   What Method?   Injections   Stripping   Ambulatory Phlebectomy   Laser closure (Endovenous/Catheter Based)   Ligation   Ligation     What have your results been?     Habits     Alcoholic Beverages   Yes   I-3 times per week   Exercise:   Regular   I-3 times per week   Seldom   No   If so, lif so, lif so, lif so, please inform how many   per week   Seldom   No   Illicit Drug Use:   Yes   No   If so, lif so, lif so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   For Women Only- Pregnancy History:   | Does walking/exercising relieve y         | ou from discomfort or       | make it worse? 🛛 🗌 Re         | lieves 🖂 Worser          | ns                           |
| What Method?   Injections   Stripping   Ambulatory Phlebectomy   Laser closure (Endovenous/Catheter Based)   Ligation   Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes   No   If so, please inform how many   per week   Exercise:   Regular   1-3 times per week   Seldom   No   Illicit Drug Use:   Yes   No   If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History Have you ever had surgery?   Yes   No   If yes, please explain below:   For Women Only- Pregnancy History:   | Have you been treated for your v          | eins before?                | 🛛 Yes 🛛 🗆 No                  |                          |                              |
| Injections □ Ultrasound-guided injections   Stripping □ Radiofrequency closure   Ambulatory Phlebectomy □ Laser closure (Endovenous/Catheter Based)   Ligation □ Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages Yes   No If so, please inform how many   per week   Exercise:   Regular   1-3 times per week   Seldom   No   Illicit Drug Use:   Yes   No   If so, list type of drug:    List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.) Surgical History Have you ever had surgery? Please list all medical surgeries (including dates) For Women Only- Pregnancy History:  | By Whom?                                  |                             | When?                         |                          |                              |
| Stripping Radiofrequency closure   Ambulatory Phlebectomy Laser closure (Endovenous/Catheter Based)   Ligation Laser for spider veins   What have your results been?   Habits   Habits   Alcoholic Beverages Yes   No If so, please inform how many   per week   Exercise: Regular   1-3 times per week   Seldom   Illicit Drug Use:   Yes   No   If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History Have you ever had surgery?   Yes   No   If yes, please explain below:   For Women Only- Pregnancy History:  | What Method?                              |                             |                               |                          |                              |
| Ambulatory Phlebectomy Laser closure (Endovenous/Catheter Based)   Ligation Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   No If so, please inform how many   per week Seldom   Illicit Drug Use: Yes   Yes No   If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History   Have you ever had surgery?   Yes   No   If yes, please explain below:   For Women Only- Pregnancy History:   |   |                             | Ultrasound-g                  | uided injections         |                              |
| Ligation Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   No If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History   Have you ever had surgery?   Yes   No   If yes, please explain below:   For Women Only- Pregnancy History:   | Stripping                                 |                             | Radiofrequer                  | ncy closure              |                              |
| Ligation Laser for spider veins   What have your results been?   Habits   Alcoholic Beverages   Yes No   If so, please inform how many per week   Exercise: Regular   1-3 times per week Seldom   No If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History   Have you ever had surgery?   Yes   No   If yes, please explain below:   For Women Only- Pregnancy History:   |   | ry Phlebectomy              | Laser closure                 | (Endovenous/Cathe        | eter Based)                  |
| Habits         Alcoholic Beverages       Yes       No       If so, please inform how many per week         Exercise:       Regular       1-3 times per week       Seldom       Never         Tobacco Use:       Yes- quantity:       Previously Smoked- Quit Date:       No         Illicit Drug Use:       Yes       No       If so, list type of drug:       No         List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)       Surgical History         Have you ever had surgery?       Yes       No       If yes, please explain below:         Please list all medical surgeries (including dates)       If yes, please explain below:       For Women Only- Pregnancy History:  |   |                             | Laser for spic                | ler veins                |                              |
| Habits         Alcoholic Beverages       Yes       No       If so, please inform how many per week         Exercise:       Regular       1-3 times per week       Seldom       Never         Tobacco Use:       Yes- quantity:       Previously Smoked- Quit Date:       No         Illicit Drug Use:       Yes       No       If so, list type of drug:       No         List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)       Surgical History         Have you ever had surgery?       Yes       No       If yes, please explain below:         Please list all medical surgeries (including dates)       If yes, please explain below:       For Women Only- Pregnancy History:  | What have your results been?              |                             |                               |                          |                              |
| Alcoholic Beverages Yes No If so, please inform how many per week   Exercise: Regular 1-3 times per week Seldom Never   Tobacco Use: Yes- quantity: Previously Smoked- Quit Date:   Illicit Drug Use: Yes No If so, list type of drug:   |   |                             |                               |                          |                              |
| Alcoholic Beverages Yes No If so, please inform how many per week   Exercise: Regular 1-3 times per week Seldom Never   Tobacco Use: Yes- quantity: Previously Smoked- Quit Date:   Illicit Drug Use: Yes No If so, list type of drug:   | Hahits                                    |                             |                               |                          |                              |
| Exercise: Regular 1-3 times per week Seldom Never   Tobacco Use: Yes- quantity: Previously Smoked- Quit Date: No   Illicit Drug Use: Yes No If so, list type of drug: No   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History Have you ever had surgery?    Have you ever had surgeries (including dates)   For Women Only- Pregnancy History:   |   | No If so ple                | ase inform how many           |                          | ner week                     |
| Tobacco Use: Yes- quantity: Previously Smoked- Quit Date:   Illicit Drug Use: Yes No   If so, list type of drug: If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History   Have you ever had surgery? Yes   Please list all medical surgeries (including dates)   For Women Only- Pregnancy History:  | •   |                             |                               | eldom                    | <u> </u>                     |
| Illicit Drug Use: Yes No If so, list type of drug:   List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)   Surgical History   Have you ever had surgery? Yes   Please list all medical surgeries (including dates)   For Women Only- Pregnancy History:  |   |                             | •                             |                          |                              |
| List any health problems (examples are- arthritis, high blood pressure, high cholesterol, diabetes, heart disease, asthma etc.)  Surgical History Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   |   |                             | •                             |                          | NO                           |
| Surgical History Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:  |   |                             |                               | l diabatas baart disa    | nco acthma atc.)             |
| Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   | List any nearth problems (example         | es are- artifitis, high bio | ou pressure, myn cholesterol  | i, didbetes, neart diset | use, ustriinu etc.j          |
| Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   |   |                             |                               |                          |                              |
| Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   |   |                             |                               |                          |                              |
| Have you ever had surgery? Yes No If yes, please explain below: Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   |   |                             |                               |                          |                              |
| Please list all medical surgeries (including dates) For Women Only- Pregnancy History:   | - ·                                       |                             |                               |                          |                              |
| For Women Only- Pregnancy History:   | Have you ever had surgery?                |                             | If yes, please explain be     | low:                     |                              |
|  | Please list all medical surgeries (includ | ing dates)                  |                               |                          |                              |
|  |   |                             |                               |                          |                              |
|  |   |                             |                               |                          |                              |
|  | For Women Only- Pregnancy History         | y:                          |                               |                          |                              |
| Number of Births: Number of Miscarriages:  | Number of Births:                         |                             | Number of Miscarriages:       |                          |                              |
| Vein Questionnare Ciao Bella Medical Spa and Vein Clinic, PLC.   | Vein Questionnare                         |                             |                               | Ciao Bella Medico        | al Spa and Vein Clinic, PLC. |

| Family History                       |                      |                  |                        |
|--------------------------------------|----------------------|------------------|------------------------|
| Deep Venous Thrombosis (DVT) Dulmona | ary Embolism (PE)    | Venous Ulcers    | Varicose/ Spider Veins |
|                                      |                      |                  |                        |
|                                      |                      |                  |                        |
|                                      |                      |                  |                        |
|                                      |                      |                  |                        |
| Do you have allergies? 🛛 🗌 Yes       | No If yes please ex  | plain:           |                        |
|                                      |                      | Vicryl           |                        |
|                                      |                      | Other:           |                        |
| Cosmetic Products                    | _ Seasonal Allergies | <u></u>          |                        |
| Are you taking any of the following? | 🗌 Yes 🗌 No           |                  |                        |
| Blood Thinners                       | Hydroquinone         | Vitamin E        |                        |
| NSAIDs (Advil, Aleve, Naprosyn)      |                      | St. John's Wort  |                        |
| Retin A                              | <br>Antivirals       | Gold Therapy     |                        |
| □ Accutane                           | Topical Steroids     | Iron Supplements | S                      |
|                                      |                      |                  |                        |

## **Current Medications**

| Medications | Dosage | Frequency | Reason for taking each medication: |
|-------------|--------|-----------|------------------------------------|
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |
|             |        |           |                                    |

Patient Signature:

Date:

## PHYSICIAN SECTION ONLY (Do NOT fill out below; For physician use only)

**History of Present Illness:** 

**Review of Symptoms:** 

**Physical Exam:** 

Assessment:

| Venous Ultrasound   | Start/Continue Compression Stockings |  |
|---------------------|--------------------------------------|--|
| Return with results | Cosmetic Sclerotherapy               |  |
|                     | Lower Extremity Venogram/ MRV        |  |

Physician's Signature:

Date: