

EMORY

VEIN CENTER

Vein Center Questionnaire

This form will be submitted to your insurance company to determine medical necessity.

Please answer **all** questions with as much information as possible.

Name _____ Date _____

Medications for varicose veins you are currently taking: (including Tylenol, Advil, etc.). Please indicate how long these have been taken and indicate the dosage:

Previous surgeries/treatment for varicose veins to include any sclerotherapy with dates:

Do you exercise on a regular basis? _____ What type of exercise, how often and since when? _____

How many times during the day do you elevate your legs? If not, why are you unable to do so? (for example, type of work, activities you are involved in, etc.) _____

Are you wearing support hose or compression hose on a regular basis? _____

If not, why are you unable to wear them? _____

What is the strength of stockings you are wearing? _____

How often and since when? _____

Does wearing the hose result in a significant improvement in your symptoms? _____

Do your daily activities require prolonged periods of standing/sitting? _____

If yes, what activity requires periods of sitting or standing? _____

How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities? _____

Do you have any of the following symptoms associated with your legs?

___ Pain

___ Discoloration

___ Swelling, how often and since when? _____

___ Family history of varicose veins? If yes who? _____

___ Blood clot (phlebitis)? If so, where? _____

___ Recent weight loss? If yes how much? _____

___ Bleeding from vein? How many times within the past six months? _____

___ Other, please explain: _____

___ Tired achy feeling

___ Ulceration or skin breakdown

___ Dermatitis (skin inflammation)

___ Are you pregnant? ___ Number of children? ___ Ages? _____

___ Other symptoms? Please explain _____

For office use only