Marina Laser Vein Center

Vein History and Medical Necessity

Name _____ Date _____

1. Which of the following are causing you concern? (Circle all that apply)

Spider Veins **Bulging Varicose Veins** **Leg swelling**

2. How long have your veins been a problem?_____

3. Do your veins limit your daily activities due to discomfort? YES NO

4. Does prolonged sitting or standing aggravate your veins? YES NO

5. Have you ever noticed any of the following occur during activity or after prolonged standing? (Circle all that apply)

Aching **Fatigue** **Swelling** **Itching** **Pain** **Burning**

Exercise intolerance **Feeling of heaviness** **Skin changes**

6. Have you ever had any of the following? (Circle all that apply)

Bleeding from a vein **Slow or non-healing skin ulceration**

Significant, recurrent superficial phlebitis **Darkening of the skin**

7. Have you ever been treated for ulcerations or a blood clot in your leg? If yes, when and which leg? What was done?

_____

_____

_____

8. Are you allergic to Lidocaine? YES NO

9. In past months or years, how have you attempted to manage your varicose vein symptoms? (circle all that apply)

Compression Stockings **Attempted weight loss** **Exercise**

Leg elevation **Medications (Motrin, aspirin, etc.)**

10. Do you experience any of the following symptoms? (circle all that apply)

Chest pain **Shortness of Breath** **Prolonged Bleeding**

Fevers **Chronic Cough** **New onset of leg swelling**

Fainting Easily **Stroke**

Patient's signature _____

Physician's signature _____