

VALLEY IMAGING CONSULTANTS, LLC.

VARICOSE VEIN HISTORY

Patient Name: _____

Date of Birth: _____

If you have been treated in the past for varicose veins and would like for our office to obtain past records (consults, testing, procedures), please provide the following information and also sign the "Medical Record Release" form.

Have you previously had any of the following treatments for your veins?

___ Vein Stripping

___ Phlebectomy

___ Vein Ablation

___ Sclerotherapy Injections

Description of Past Vein Treatment (include approximate dates and physician name and/or facility location):

ANSWERS TO THE FOLLOWING QUESTIONS ARE REQUIRED BY MANY INSURANCE COMPANIES TO DETERMINE IF YOUR VEIN TREATMENT WILL BE COVERED BY YOUR POLICY, OR MAY BE CONSIDERED COSMETIC.

How long ago did you start experiencing problems with your veins? _____

Do you experience any of the following symptoms? (Check all that apply)

___ Aching/Throbbing

___ Ankle/Leg Swelling

___ Sharp stabbing pain

___ Itching/Burning

___ Bleeding Veins

___ Vein Ulcers

___ Heaviness/Fatigue

___ Eczema

___ Restless legs

OTHER SYMPTOMS: _____

Have you been diagnosed with any of the following?

(Give approximate year/date diagnosed)

___ Phlebitis

___ Blood Clot

___ Stasis Dermatitis

___ Vein Hemorrhage

___ Deep Vein Thrombosis (DVT)

___ Venous Ulcers

___ Leg injury (fracture/break)

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Which conservative treatments have you attempted? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Compression Hosiery | <input type="checkbox"/> Avoiding prolonged standing or sitting |
| <input type="checkbox"/> Leg Elevations | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Medications (Tylenol, Aspirin, Motrin) |

Current Occupation, Employer, Job title: _____

- Does your occupation require extended periods of standing or sitting? (if yes please describe):

- Are there other routine activities that make your symptoms worse? (please describe):

- Do you have any family members with varicose veins? (list which family member):

Patient Signature

Date