(REQUIRED for Pre-Certification of Services by Your Insurance Carrier) **VEIN INSTITUTE OF NJ - PATIENT VENOUS HISTORY**

Patient Name ________________________________ Date of Birth ________________________________

List any allergies ________________________________ List current medications:________________________________

Your insurance carrier (including Medicare) may require a minimum of at least 3-6 months of "conservative, non-operative treatment" in order for them to pre-approve/make payment for your services. The insurance carriers define "conservative, non-operative treatment" to include: "Mild exercise, periodic leg elevation, weight loss, compressive therapy (stockings), and avoidance of prolonged inactivity".** Please take your time to fill out this questionnaire. **Your carrier REQUIRES detailed responses.**

1. Social History: Smoke? ☐ **YES** ____#Packs/day **NO** ☐ Alcohol? ☐ **YES** # per day/week ___________ **NO** ☐

2. Have you had any prior treatment for varicose/spider veins? ☐ **YES** **NO** ☐

   Describe __________________________ Date (s) of treatment __________Surgery Dates_____________

3. Do you have a history of ulcerations, chronic swelling of your legs, or clots? When?________________ ☐ **YES** **NO** ☐

4. Do you have a family history of varicose/spider veins? If yes, relationship (s) to you _______________ ☐ YES **NO** ☐

5. Are you currently, or have been, on any hormone therapy or birth control pills? ☐ **YES** **NO** ☐
   If yes, please list ____

6. Have you had any pregnancies? __________ If yes, how many children do you have?______________ ☐ **YES** **NO** ☐
   If yes, did your varicose/spider veins increase after your pregnancy? ☐ **YES** **NO** ☐

7. Have you worn support hose? More than 6months? ___ # months worn_____ # years worn_____ ☐ YES **NO** ☐
   Did wearing stockings (20-30 compression or more) result in SIGNIFICANT improvement in symptoms? ☐ YES **NO** ☐

8. Are you presently employed? If yes, type of job ____ ☐ YES **NO** ☐

9. Do you sit or stand for long periods of time? Hours per day? Sitting ____hours Standing _____hours ☐ YES **NO** ☐
   What activity is preformed standing / sitting for long periods of time:________________________________
   How many times per day Must you "sit" or take a break to relieve symptoms:_____________________________

10. **Please describe how this discomfort LIMITS/IMPACTS your daily activity" (I.e Limits: Exercise, Sleep, Family Activity, job, driving)

____(please use reverse side if necessary)

11. Have you taken any pain medication for you varicose/spider veins? _____# months ______#years ☐ YES **NO** ☐
    (Including Aspirin, Tylenol, Motrin IB, Advil, etc.) If yes, please list _________________________ Dosage: ______________
    Over a 2 week timeframe - How many times must you take OTC medicine or RX medicines for pain & or swelling?__________

12. Do you elevate your legs to relieve your symptoms? ____hours/day, # months____, # years_____ ☐ YES **NO** ☐
    If yes, does it help? ☐ Temporarily ☐ YES **NO** ☐

13. Are you presently on a weight loss/weight management routine? ______# months ☐ YES **NO** ☐

14. Do you exercise? ☐ Mild/Occasional ☐ Regular Regiment ☐ Intense workout # mon hs______ ☐ **YES** **NO** ☐

PLEASE CHECK ALL THAT APPLY:

	RIGHT LEG	**LEFT LEG**
Edema (swelling)		
Pain (moderate, severe)		
Tiredness, Throbbing, Achiness, Burning, Cramping		
Ulceration		
Skin color changes		
Spider veins		
Varicose veins		

Patient Signature ________________________ Date __________ Nurse Initials_____ M.D. Signature___________________