Northwest Vascular Consultants, Inc
9701 SW Barnes Rd., Suite 140 Phone: 503-292-9565
Portland, Oregon 97225 Fax: 503-292-9478

Venous Health history Form

To our potential varicose vein surgery patients:

Your insurance company may require the question and criteria below to be met before authorization can be considered or approved for varicose vein surgery. Please read this carefully and complete fully. Thank you.

Patient Name (print):_____________________________________ Date of Birth:_______________

1. **What are your symptoms/problems?** (Circle all that apply) ( ) Mild ( ) Moderate ( ) Severe

Leg pain/discomfort	yes	no			
Phlebitis (swelling of vein caused by a blood clot)	yes	no	Do you have pain with meal preparation?	Yes	no
Recurrent (more than once)	yes	no	Do you have pain with household chores?	Yes	no
Bleeding Varicose Veins	yes	no	Do you have pain while grocery shopping?	Yes	no
Ulcers or open sores	yes	no	Do you have pain with bending/squatting?	Yes	no
Itching over the varicose veins	yes	no	Do you stand for long periods of time?	Yes	no
Heaviness or aching in the legs	yes	no	Do you sit for long periods of time?	Yes	no
Burning sensation in legs	yes	no	Do you have pain with exercise?	Yes	no
Veins that have spontaneously ruptured leaving a large bruise	yes	no			
Brown pigmentation changes around the ankle and lower leg	yes	no			

2. **What conservative measures have you taken to alleviate symptoms?** (Circle all that apply)

Leg Elevation	yes	no	Over the counter pain relievers	yes	no
Exercise	yes	no	Weight loss	yes	no

3. **Are you allergic to the following?**

Topical Iodine/Betadine	yes	no	Lidocaine	yes	no

Have you had and adverse reaction to Epinephrine?____________________________________

4. **Compression Stockings (minimum of 20mmhg) for three months or more Yes No**
If yes: How long? _____________ Compression ( )Not known ( ) 20-30 ( ) 30-40 ( ) 40+
When was your prescription for compression socks filled?____________________________
Who wrote your prescription for compression socks?______________________________
Have you been wearing your compression socks on a daily basis?_______________
If yes, are they relieving your symptoms?____________________________________
If no, why did you discontinue wearing them?________________________________

5. **Have symptoms caused you to repeatedly miss work, modify your duties or seek assistance with activities of daily living or normal house hold activities?** (If any of the above, please mark yes)
( ) yes ( ) no - If yes, please describe in question #6

6. **Explain significant and specific functional impairment and/or limitations of activities of daily living:** (i.e.: indoor/outdoor chores, meal preparation/occupational limitations…)
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To the best of my knowledge, the above information is accurate and complete.

_______________________________________ ___________________________
(Patient Signature) (Date)