Southeast Interventional Associates

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Place label here

Vein Center at Brinton Lake

Please fill out this questionnaire carefully and to the best of your ability. All of the following information will be used to precertify you with your insurance company should you be a candidate for any of the procedures that we offer.

Vascular History

Do you have or have you ever been diagnosed with the following:

-Varicose Veins	☐ Y ☐ N	Leg: ☐ R	☐ L	
-Phlebitis	☐ Y ☐ N	Leg: ☐ R	☐ L	
-Blood Clots	☐ Y ☐ N	Leg: ☐ R	☐ L	
-Deep Vein Thrombosis (DVT)	☐ Y ☐ N	Leg: ☐ R	☐ L	
-Saphenous Vein Reflux	☐ Y ☐ N	Leg: ☐ R	☐ L	

Do you experience any of the following symptoms in your leg(s):

-Aching/ Pain	☐ Y ☐ N	Leg: ☐ R	☐ L
-Heaviness	☐ Y ☐ N	Leg: ☐ R	☐ L
-Tiredness/Fatigue	☐ Y ☐ N	Leg: ☐ R	☐ L
-Itching/Burning	☐ Y ☐ N	Leg: ☐ R	☐ L
-Swelling	☐ Y ☐ N	Leg: ☐ R	☐ L
-Cramps	☐ Y ☐ N	Leg: ☐ R	☐ L
-Restless/Legs	☐ Y ☐ N	Leg: ☐ R	☐ L
-Throbbing	☐ Y ☐ N	Leg: ☐ R	☐ L
-Skin or Ulcer Problems	☐ Y ☐ N	Leg: ☐ R	☐ L

-Other: _____

-How long have you suffered from these symptoms? Please be specific: _____

_____

_____

Which of the following do you currently do or have you done in the past to improve your symptoms:

-Medication for Pain	☐	Does it provide relief?	☐ Y ☐ N	How often do you take the medication?	_____
-Elevation of Legs	☐	Does it provide relief?	☐ Y ☐ N	How long have you been elevating?	_____
-Compression Stockings	☐	Does it provide relief?	☐ Y ☐ N	How long have you worn stockings?	_____

Family History

Have any of your family members had the following:

-Varicose Veins	☐ Y ☐ N	Relationship: _____
-Vein Stripping	☐ Y ☐ N	Relationship: _____
-Blood Coagulation Disorder	☐ Y ☐ N	Relationship: _____
-Blood Clots	☐ Y ☐ N	Relationship: _____
-Stroke, Heart Attacks, or Pulmonary emboli	☐ Y ☐ N	Relationship: _____

Vein Treatment History

Have you ever been treated for varicose veins with:

-Sclerotherapy ☐ Y ☐ N Leg: ☐ R ☐ L When: _____

-Laser therapy ☐ Y ☐ N Leg: ☐ R ☐ L When: _____

-Phlebectomy ☐ Y ☐ N Leg: ☐ R ☐ L When: _____

-Vein Stripping ☐ Y ☐ N Leg: ☐ R ☐ L When: _____

-RF Ablation (VNUS CLOSURE®) ☐ Y ☐ N Leg: ☐ R ☐ L When: _____

Personal Activities List

-Does your work require prolonged periods of standing or sitting? ☐ Y ☐ N
Please Specify- Sitting: _____ Min / HRS Standing: _____ Min / HRS

-Do you smoke? ☐ Y ☐ N

-Do you exercise regularly? ☐ Y ☐ N How often? _____

-Pregnancies? ☐ Y ☐ N How Many? _____

Who referred you to our practice? _____

Please list any additional information that you would like us to know, such as how these symptoms interfere with your daily living or activities:

_____

_____

_____

_____

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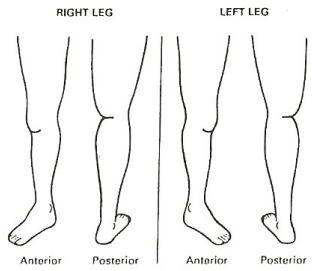
Physical Exam:



CEAP Clinical Signs:

Right Leg: ☐No signs of venous disease ☐Visible Varicose Veins ☐Pigmentation ☐Healed ulcers ☐Spider Veins ☐Edema ☐Active ulcers

Left Leg: ☐No signs of venous disease ☐Visible Varicose Veins ☐Pigmentation ☐Healed ulcers ☐Spider Veins ☐Edema ☐Active ulcers

Clinical Assessment: ☐Chronic venous insufficiency ☐RT ☐LT

☐Other:_____ ☐RT ☐LT

☐Other:_____ ☐RT ☐LT

Treatment Plan:

☐Duplex Ultrasound ☐RT ☐LT

☐Sclerotherapy ☐RT ☐LT

☐Medical Compression Stockings ☐RT ☐LT

☐Other: _____

Signature of Screening Provider: _____