EMORY
VEIN CENTER

Vein Center Questionnaire

This form will be submitted to your insurance company to determine medical necessity.

Please answer **all** questions with as much information as possible.

Name_____Date_____

Medications for varicose veins you are currently taking: (including Tylenol, Advil, etc.). Please indicate how long these have been taken and indicate the dosage:

_____
_____

Previous surgeries/treatment for varicose veins to include any sclerotherapy with dates:

_____
_____

Do you exercise on a regular basis? _____ What type of exercise, how often and since when? _____
_____

How many times during the day do you elevate your legs? If not, why are you unable to do so? (for example, type of work, activities you are involved in, etc.)_____
_____

Are you wearing support hose or compression hose on a regular basis? _____
If not, why are you unable to wear them? _____
What is the strength of stockings you are wearing? _____
How often and since when? _____
Does wearing the hose result in a significant improvement in your symptoms? _____

Do your daily activities require prolonged periods of standing/sitting? _____
If yes, what activity requires periods of sitting or standing? _____
How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities?_____

Do you have any of the following symptoms associated with your legs?
____Pain
____Discoloration
____Swelling, how often and since when? _____
____Family history of varicose veins? If yes who? _____
____Blood clot (phlebitis)? If so, where? _____
____Recent weight loss? If yes how much? _____
____Bleeding from vein? How many times within the past six months? _____
____Other, please explain: _____
____Tired achy feeling
____Ulceration or skin breakdown
____Dermatitis (skin inflammation)
____Are you pregnant? ____ Number of children? ____Ages? _____
____Other symptoms? Please explain_____

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