☐ E
☐ S

TRUFFLES
VEIN SPECIALISTS

Insurance: _____

2nd Insurance: _____

Wait time: _____

Date: _____

A. Venous Health History Form

Patient please complete questions 1-12

Patient Name: _____ **Date of Birth:** _____

SSN#: _____ **Primary Care Physician:** _____

What is the reason for your visit?

_____

_____

Venous Health History

1. Have you ever a procedure on your legs or pelvis for vein disease? ☐ Yes ☐ No

Endovascular Laser Treatment?	☐ Yes ☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Radiofrequency Ablation?	☐ Yes ☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Venaseal?	☐ Yes ☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Sclerotherapy?	☐ Yes ☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Vein Stripping?	☐ Yes ☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Stent Procedure in Pelvis?	☐ Yes ☐ No	☐ RT Side	☐ LT side	☐ Both Side

2. Have you ever had vein injections? ☐ Yes ☐ No ☐ RT leg ☐ LT leg ☐ Both legs

3. Have you ever had a blood clot, Deep Vein Thrombosis (DVT)? ☐ Yes ☐ No ☐ RT leg ☐ LT leg ☐ Both legs

4. Have you ever had thrombophlebitis (inflammation of the veins)? ☐ Yes ☐ No ☐ RT leg ☐ LT leg ☐ Both legs

5. Do you experience any of the following in your legs?

Pain/Aching/Cramping?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Heavy Feeling?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Varicose Veins?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Restless Legs?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Burning or Itching of Skin?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Open Wounds or Sores?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Skin Discoloration?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs
Leg or Ankle Swelling?	☐ Yes	☐ No	☐ RT leg	☐ LT leg	☐ Both legs

Rate the intensity of the pain on a scale of 1 through 10. _____

Do you ever have bleeding from Vein? ☐ Yes ☐ No ☐ RT leg ☐ LT leg ☐ Both legs

Please explain how the above symptoms in your legs effect you daily and how often:

_____

_____

6. What do you do to relieve the symptoms? (Check all that apply) ☐Wear Compression Hose ☐Elevate legs ☐Avoid walking ☐Limit daily activities ☐ Take pain medicine, including over the counter.

7. Do you wear compression stockings? ☐ Yes ☐ No.
   a. How long have you worn compression stockings?
      i. ☐ None ☐ 0-6 weeks ☐ 6 weeks - 3 months ☐ more than 3 moths

8. Do you have trouble with daily activities including work due to pain and swelling? ☐ Yes ☐ No
   Check all that apply. ☐Activities at work ☐Standing ☐Walking ☐Housework

9. Were you ever diagnosed with Venous Reflux or Venous Insufficiency? ☐ Yes ☐ No

10. Have you ever had an Ultrasound Venous Mapping? ☐ Yes ☐ No

Venous Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

CURRENT OR RECENT MEDICATIONS AND/OR VITIMINS/ SUPPLIMENTS

_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY ☐ **NONE**

Cardiovascular _____
Pulmonary_____
Gastrointestinal _____
Genitourinary_____
Endocrine _____
HIV/AIDS _____
Neurological _____
Cold Sores _____
Autoimmune _____
Hepatitis_____
Skin _____

Diabetes: _____
Hypertension: _____
Bleeding Problems:
Williebrand's Disease:
Factor ☐ II ☐V ☐VII ☐X ☐XII
☐Hemophilia
Other: _____
Clotting Problems:
Deficiency of Antithrombin:
☐Protein C ☐Protein S
☐ Factor V Leiden and Antithrombin Deficiency
Other: _____

ALLERGIES/SENSITIVITIES TO MEDICATIONS INCLUDING TOPICAL MEDICATIONS:

☐ Latex ☐ Iodine ☐ **NONE**

PAST SURGICAL HISTORY: ☐ **NONE**

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

HOSPITILIZATION Have you ever been hospitalized (other than surgeries)? ☐ Yes ☐ No

Reason: _____ Date: _____

Reason: _____ Date: _____

FAMILY HISTORY

Mother Alive Age: _____ Deceased Age:_____ Medical History_____
Father Alive Age: _____ Deceased Age:_____ Medical History:_____
Other Alive Age: _____ Deceased Age:_____ Medical History:_____

SOCIAL HISTORY

Are you a current smoker? □ current smoker □ current every day smoker □ current some day smoker □ smoker □ current status unknown □ former smoker □ nonsmoker □ unknown if ever smoked

If former smoker: How long has it been since you last smoked? □ less than one month □ 1-3 months □ 3-6- months □ 6-12 months □ 1-5 years □ 5-10 years □ more than 10 years.

If current smoker: Are you interested in quitting? □ ready to quit □ thinking about quitting □ not ready to quit

If current smoker: How many cigarettes a day do you smoke? □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 more

If current smoker: How soon after you wake up do you smoke your first cigarette? □ within 5 minutes □ 6-30 minutes □ 31-61 minutes □ after 60 minutes

If current smoker: How long do you smoke cigarettes? □ every day □ some days □ not every day

Tobacco use other than smoking: Are you an "other" tobacco user? □ Yes □ No

Did you have a drink containing alcohol in the past year? □ Yes □ No

If Yes, how often did you have a drink containing alcohol in the past year?

□ Never □ Monthly or less □ 2 -4 times a month □ 2 -3 times a week □ 4 or more times a week.

If Yes: How many drinks did you have a on a typical day when you were drinking in the past year?

□ 1 -2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks.

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily.

Do you exercise? □ Yes □ No How often? _____ (per week)

TRUFFLES

VEIN SPECIALISTS

Name: _____ DOB: _____

PLEASE FILL IN THE BUBBLE COMPLETELY TO INDICATE SYMPTOMS:

Fever	O Yes O No	Blood in stool	O Yes O No
Fatigue	O Yes O No	Vomiting	O Yes O No
Weight loss	O Yes O No	Easy bruising	O Yes O No
Blistering of skin	O Yes O No	Blood in urine	O Yes O No
Hives	O Yes O No	Frequent urination	O Yes O No
Itching	O Yes O No	Painful joints	O Yes O No
Rash	O Yes O No	Mole(s)	O Yes O No
Weakness	O Yes O No	Dry skin	O Yes O No
Sore throat	O Yes O No	Skin lesion(s)	O Yes O No
Chest pain	O Yes O No	Skin cancer	O Yes O No
Shortness of breath	O Yes O No	Tingling/Numbness	O Yes O No
Wheezing	O Yes O No	Memory loss	O Yes O No
Cough	O Yes O No	Seizures	O Yes O No
Blurred vision	O Yes O No	Depressed mood	O Yes O No
Dry eye	O Yes O No	Delusions	O Yes O No
Decreased hearing	O Yes O No	Difficulty urinating	O Yes O No
Sinus pain	O Yes O No	Muscle aches	O Yes O No
Heat intolerance	O Yes O No	Tremor	O Yes O No
Palpitations	O Yes O No	Prolonged Bleeding	O Yes O No
Abdominal pain	O Yes O No	History of DVT	O Yes O No

PATIENTS: Please stop here. The physician may go over additional questions with you.

Initial Physician Evaluation

PHYSICAL EXAMINATION Height: _____ Weight: _____

Vitals: B/P: _____ Pulse: _____ Temperature: _____

Measurements: RIGHT: Ankle: ____cm Calf: ____cm Thigh: ____cm Length: ____cm

LEFT: Ankle: ____cm Calf: _____cm Thigh: _____cm Length: _____cm

General: ☐ No Abnormalities Noted: (Findings) _____
HEENT: ☐ No Abnormalities Noted: (Findings) _____
Skin: ☐ No Abnormalities Noted: (Findings) _____
Neck ☐ No Abnormalities Noted: (Findings) _____
Chest ☐ No Abnormalities Noted: (Findings) _____
Heart ☐ No Abnormalities Noted: (Findings) _____
Breast ☐ No Abnormalities Noted: (Findings) _____
Abdomen ☐ No Abnormalities Noted: (Findings) _____
Genitalia ☐ No Abnormalities Noted: (Findings) _____
Neuro ☐ No Abnormalities Noted: (Findings) _____
Extremities ☐ No Abnormalities Noted: (Findings) _____
Right Leg ☐ No Abnormalities Noted: (Findings) _____
- Varicosities ☐ No Abnormalities Noted: (Findings) _____
- Swelling ☐ No Abnormalities Noted: (Findings) _____
- Ulcers ☐ No Abnormalities Noted: (Findings) _____
- Spider Veins ☐ No Abnormalities Noted: (Findings) _____
- Pedal Pulse ☐ No Abnormalities Notes: (Findings) _____

Left Leg ☐ No Abnormalities Noted: (Findings) _____
- Varicosities ☐ No Abnormalities Noted: (Findings) _____
- Swelling ☐ No Abnormalities Noted: (Findings) _____
- Ulcers ☐ No Abnormalities Noted: (Findings) _____
- Spider Veins ☐ No Abnormalities Noted: (Findings) _____
- Pedal Pulse ☐ No Abnormalities Notes: (Findings) _____

Assessments:

1. Venous Insufficiency (ICD 10) ☐ I87.2
2. Varicose veins of bilateral lower extremities with other complications ☐I83.893 ☐I83.891(RT) ☐ I83.892 (LT)
3. Varicose veins of bilateral lower extremities with pain ☐I83.813 ☐I83.811(RT) ☐ I83.812 (LT)
4. Pain in Leg ☐ M79.605 (LT) ☐ M79.604 (RT)
5. Restless Legs ☐ G25.81
6. Prescription for graduated, elasticized compression stockings given to patient.
   ☐ 20 – 30 mmHg, calf, closed toe compression stockings
7. Duplex or Doppler Scan order of the affected leg(s). ☐ 93970 Bilateral ☐ 93971 Unilateral
8. Return to office after ultrasound test.

PHYSICIAN TO COMPLETE:

CEAP Clinical Classifications:

(C) Class

0- Asymptomatic. No visible or palpable signs of venous disease
1 - Spider veins, reticular veins, Telangiectasias
2 - Varicose veins
3 - Edema
4 - Skin changes
5 - Healed ulcer
6 - Active ulcer

(E) Etiology: Congenital ☐ Primary Disease ☐ Secondary Disease ☐
(A) Anatomic Findings: Alone/ in combination –Superficial ☐ Deep ☐ Perforator ☐
(**P) Pathophysiology Dysfunction:** Reflux ☐ Obstruction ☐ Both Reflux & Obstruction ☐

F. Projected Treatment Plan

Date: _____
Patient is symptomatic with varicosities despite compliance with conservative therapy and has failed conservative treatment. Medical necessity- this condition requires medical treatment to allow patient to return to a normal quality of life.

Recommendation of the following procedure(s)

☐ Endovenous ablation- RFA of Greater Saphenous Vein	Right Date_____ Left Date: _____Bilateral ___
☐ Endovenous ablation- RFA of Lesser Saphenous Vein	Right Date_____ Left Date: _____Bilateral ___
☐ Endovenous ablation- RFA of Perforating Vein (s) -RFS	Right Date_____ Left Date: _____Bilateral ___
☐ Sclerotherapy	Right Date_____ Left Date: _____Bilateral ___
☐ Ultrasound Guided Sclerotherapy	Right Date_____ Left Date: _____Bilateral ___
☐ Stab Phlebectomy	Right Date_____ Left Date: _____Bilateral ___
☐ Other: _____	Right Date_____ Left Date: _____ Bilateral ___

Physician Comments: _____
_____
_____

Date: _____
Patient is asymptomatic and cosmetic in nature

☐ Sclerotherapy -Spider/ Telangiectatic Veins	Right Date_____ Left Date: _____Bilateral ___
☐ Ultrasound Guided Sclerotherapy	Right Date_____ Left Date: _____Bilateral ___
☐ Stab Phlebectomy	Right Date_____ Left Date: _____Bilateral ___

Physician Comments: _____
_____
_____

_____
Paul D. Feldman, M.D. FACS, FICS **Date:** _____