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Insurance: \_\_\_\_\_

2<sup>nd</sup> Insurance: \_\_\_\_\_

Wait time: \_\_\_\_\_

# TRUFFLES

◇ VEIN SPECIALISTS ◇

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 Sides

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  = or > 6 weeks  = or >8 weeks  = or >3 months  Other: \_\_\_\_\_
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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mother	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brother(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sister(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**CURRENT OR RECENT MEDICATIONS AND/OR VITIMINS/ SUPPLIMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY**

Cardiovascular \_\_\_\_\_  
 Pulmonary \_\_\_\_\_  
 Gastrointestinal \_\_\_\_\_  
 Genitourinary \_\_\_\_\_  
 Endocrine \_\_\_\_\_  
 HIV/AIDS \_\_\_\_\_  
 Neurological \_\_\_\_\_  
 Cold Sores \_\_\_\_\_  
 Autoimmune \_\_\_\_\_  
 Hepatitis \_\_\_\_\_  
 Skin \_\_\_\_\_

**NONE**

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: \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Endovenous ablation- RFA of Greater Saphenous Vein    | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Endovenous ablation- RFA of Lesser Saphenous Vein     | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Endovenous ablation- RFA of Perforating Vein (s) -RFS | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Sclerotherapy   | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Ultrasound Guided Sclerotherapy                       | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Stab Phlebectomy                                      | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Other: _____  | Right Date_____ Left Date: _____ Bilateral ____ |

**Physician Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient is asymptomatic and cosmetic in nature**

- |  |   |
|--|---|
| <input type="checkbox"/> Sclerotherapy -Spider/ Telangiectatic Veins | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Ultrasound Guided Sclerotherapy             | Right Date_____ Left Date: _____ Bilateral ____ |
| <input type="checkbox"/> Stab Phlebectomy                            | Right Date_____ Left Date: _____ Bilateral ____ |

**Physician Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Paul D. Feldman, M.D. FACS, FICS**

**Date:** \_\_\_\_\_