Marina Laser Vein Center

Vein History and Medical Necessity

Name ___________________________________ Date _____________________

1. Which of the following are causing you concern? (Circle all that apply)
   - Spider Veins
   - Bulging Varicose Veins
   - Leg swelling

2. How long have your veins been a problem? _____________________________

3. Do your veins limit your daily activities due to discomfort? YES NO

4. Does prolonged sitting or standing aggravate your veins? YES NO

5. Have you ever noticed any of the following occur during activity or after prolonged standing? (Circle all that apply)
   - Aching
   - Fatigue
   - Swelling
   - Itching
   - Pain
   - Burning
   - Exercise intolerance
   - Feeling of heaviness
   - Skin changes

6. Have you ever had any of the following? (Circle all that apply)
   - Bleeding from a vein
   - Slow or non-healing skin ulceration
   - Significant, recurrent superficial phlebitis
   - Darkening of the skin

7. Have you ever been treated for ulcerations or a blood clot in your leg? If yes, when and which leg? What was done?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
8. Are you allergic to Lidocaine? YES NO

9. In past months or years, how have you attempted to manage your varicose vein symptoms? (circle all that apply)

   Compression Stockings    Attempted weight loss    Exercise
   Leg elevation             Medications (Motrin, aspirin, etc.)

10. Do you experience any of the following symptoms? (circle all that apply)

    Chest pain    Shortness of Breath    Prolonged Bleeding
    Fevers        Chronic Cough          New onset of leg swelling
    Fainting Easily    Stroke

Patient’s signature ______________________________________________________

Physician’s signature __________________________________________________