South Jersey Radiology Associates, P.A.

VASCULAR CARE CENTER - PATIENT VENOUS HISTORY (Required for Pre-Certification of Services)

Patient Name ______________________ Date of Birth ______________________

List any allergies ______________________ List current Medications: ______________________

Social History: Smoke? ☐ YES ____#Packs/day NO ☐ Alcohol? ☐ YES # per day/week ________ NO ☐

1. Have you had any prior treatment for varicose/spider veins? ☐ YES NO ☐
   Describe ______________ Date (s) of treatment ________ Surgery Dates ________
   Type of agent (s) used, if known ______________

2. Do you have a history of ulcerations, chronic swelling of your legs, or clots? When? ☐ YES NO ☐

3. Do you have a family history of varicose/spider veins?
   If yes, relationship (s) to you ______________________ ☐ YES NO ☐

4. Are you currently, or have been, on any hormone therapy or birth control pills? ☐ YES NO ☐
   If yes, please list ______________________

5. Have you had any pregnancies? If yes, how many? ______________ ☐ YES NO ☐
   If yes, did your varicose/spider veins increase after your pregnancy? ☐ YES NO ☐

6. Have you worn support hose? More than 6months? ____ # months worn_____ ☐ YES NO ☐

7. Are you presently employed? If yes, type of job ______________________ ☐ YES NO ☐

8. Do you sit or stand for long periods of time? ☐ YES NO ☐
   How many hours per day? Sitting ______# of hours Standing _______ # of hours

9. **Please describe "level of discomfort, pain"? Frequency/ timing of discomfort/pain? ** *How it affects daily living ?***
   (Please use details. This information is most often ***required*** *to "pre-certify medical services" with your insurance carrier.)*

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____(please use reverse side if necessary)

10. Have you taken any pain medication for you varicose/spider veins? _____# months ____#years ☐ YES NO ☐
    (Including Aspirin, Tylenol, Motrin IB, Advil, etc.) If yes, please list ______________________

11. Do you take Coumadin, Plavix, or Aspirin on a regular basis? ☐ YES NO ☐

12. Do you elevate your legs to relieve your symptoms? ___hours/day , # months____, # years_____ ☐ YES NO ☐
    If yes, does it help? ☐ YES NO ☐

Have you received and read the Sclerotherapy and laser brochures? ☐ YES NO ☐

PLEASE CHECK ALL THAT APPLY:

	RIGHT LEG	LEFT LEG
Edema (swelling)		
Pain (Mild, moderate, severe)		
Tiredness, Throbbing, Achiness		
Ulceration		
Skin color changes		
Spider veins		
Varicose veins		

Patient Signature ______________ Date ________ Nurse Initials_______ M.D. Signature______________