

# J. THOMAS CRITCHLOW, M.D.

## VEIN QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referred by \_\_\_\_\_

1. How many years have you noticed this problem? \_\_\_\_\_

2. Have you ever been previously treated? \_\_\_\_\_

If so, when and where? \_\_\_\_\_

Injections?	_____
Cautery?	_____
Laser?	_____
Surgery?	_____
Worn Stockings?	_____
Medication? (i.e., Motrin, Ibuprofen, etc.)?	_____
Tried to Lose Weight?	_____
Leg Elevation?	_____
Exercise?	_____

3. When did you first notice the veins?

Age	_____
Before/During/After Pregnancy	_____

4. Is there a family history of varicose/spider veins? \_\_\_\_\_

5. Any personal history of:

Thrombophlebitis?	_____
Pulmonary Embolism?	_____
Blood Clots?	_____
Lupus?	_____
Bleeding Disorders?	_____
Leg Ulcers?	_____
Cancer?	_____

6. Do you stand/sit for long periods of time? \_\_\_\_\_

7. Are you presently pregnant or planning a pregnancy soon? \_\_\_\_\_

8. Are you currently taking any medication for your veins? \_\_\_\_\_

9. Do your veins/legs:

	Right Leg	Left Leg
Ache/Pain?	_____	_____
Swell?	_____	_____
Itch/Burn/Sting?	_____	_____
Cause Cramping	_____	_____
Become Red?	_____	_____
Feel Heavy?	_____	_____
Throb?	_____	_____
Feel Tired/Fatigued?	_____	_____
Have Discoloration?	_____	_____
Have a Change in Skin Texture?	_____	_____

10. Does the appearance of the veins bother you? \_\_\_\_\_

11. Do you have a feeling of unpleasant sensations of one sort or another (creeping, tingling, aching) in the legs when sitting or lying down? \_\_\_\_\_

Does this cause a strong urge to move the legs and does such movement (usually walking) temporarily relieve the discomfort? \_\_\_\_\_

If yes...

Do these feeling occur during the day?	_____
Do these feelings occur during the night?	_____
Does your bed partner complain of you having frequent leg movement?	_____
Does anyone else in your family have similar symptoms?	_____
How long have you had these symptoms?	_____
Do you currently have these symptoms?	_____

## AUTHORIZATIONS

I hereby authorize Dr. Critchlow to furnish information to insurance carriers and referred physicians concerning my illness and treatment.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I hereby authorize my insurance benefits to be paid directly to J. Thomas Critchlow, M.D. I understand I am financially responsible for all charges.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

Medicare requires that **at least one** of the following criteria be met before they will pay for your procedure.

Have you had:

1. Persistent symptoms interfering with activities of daily living in spite of conservative non-surgical management? Symptoms include <b>any</b> of the following: aching or cramping or burning or itching and/or swelling during activity or after prolonged standing.	Right Leg	<b>Circle One</b> Yes No	
	Left Leg	Yes	No

OR

2. Significant recurrent attacks of superficial phlebitis (blood clots)?	Right Leg	Yes	No
	Left Leg	Yes	No

OR

3. Recurrent hemorrhage from a ruptured varix (bleeding from veins) or bleeding requiring a blood transfusion?	Right Leg	Yes	No
	Left Leg	Yes	No

OR

4. Skin ulceration or sore?	Right Leg	Yes	No
	left Leg	Yes	No

Your private insurance also requires that **ALL** of the following have been tried for at least **3 months** before they will pay for your operation.

Have you tried:	Yes	No
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1. Mild Exercise	_____	_____
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AND

2. Avoidance of prolonged immobility	_____	_____
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AND

3. Compressive stocking (at least 30mm of Mercury)	_____	_____
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AND

4. Periodic Elevation of Legs	_____	_____
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\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date