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:

		Circle One	
1. Persistent symptoms interfering with activities of daily living in spite of conservative non-surgical management? Symptoms include **any** of the following: aching or cramping or burning or itching and/or swelling during activity or after prolonged standing.	Right Leg	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
1. Mild Exercise	_____	_____
AND		
2. Avoidance of prolonged immobility	_____	_____
AND		
3. Compressive stocking (at least 30mm of Mercury)	_____	_____
AND		
4. Periodic Elevation of Legs	_____	_____

_____ _____ _____

Print Name Signature Date