VASCULAR & INTERVENTIONAL PHYSICIANS

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VARICOSE VEIN QUESTIONNAIRE — PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE IN FULL.
THE INFORMATION YOU PROVIDE IS IMPORTANT FOR YOU CARE.

PATIENT NAME_____ DATE OF BIRTH_____ DATE_____

ADDRESS_____

PHONE NUMBER_____ EMAIL_____

MARITAL STATUS ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

OCCUPATION_____ DO YOU HAVE CHILDREN?_____ IF SO, HOW MANY?_____

HOW DID YOU HEAR ABOUT US_____

DO YOU SMOKE?_____ IF SO, HOW MUCH PER DAY?_____ HOW LONG HAVE YOU SMOKED? _____

HOW MANY GLASSES OF ALCOHOL DO YOU HAVE PER WEEK?_____ DO YOU USE RECREATIONAL DRUGS?_____

IF SO, WHAT KIND?_____ IF SO, HOW OFTEN?_____

HOW LONG HAVE YOU HAD VARICOSE VEINS?_____ DO THEY INTERFERE WITH WORK?_____

PREFERRED LANGUAGE_____GENDER_____RACE_____

WHAT ARE YOUR SYMPTOMS?

☐ THROBBING ☐ ACHING ☐ HEAVY/FULL ☐ SHARP PAIN ☐ CRAMPING
☐ ITCHING ☐ BURNING ☐ SWELLING ☐ ULCERS OR SORES ☐ BRUISE EASY
☐ SKIN COLOR CHANGES ☐ OTHER: _____

WHAT MAKES IT WORSE?

☐ STANDING ☐ SITTING ☐ WALKING ☐ EXERCISE ☐ HEAT
☐ PRE-MENSTRUAL ☐ NIGHT ☐ WORSENING OF SYMPTOMS WITH PREGNANCY
☐ OTHER: _____

WHAT MAKES IT BETTER?

☐ ELEVATION ☐ EXERCISE ☐ COOLNESS ☐ COMPRESSION STOCKINGS
☐ OTHER: _____

HAVE YOU EVER WORN COMPRESSION STOCKINGS?_____ IF SO, FOR HOW LONG? _____

WERE THEY FULL LENGTH OR KNEE HIGH?_____ DID THEY HELP? _____

PREVIOUS TREATMENT?

☐ STRIPPING	☐ RIGHT LEG	☐ LEFT LEG	DATE: _____
☐ PHLEBECTOMY	☐ RIGHT LEG	☐ LEFT LEG	DATE: _____
☐ RADIOFREQUENCY ABLATION	☐ RIGHT LEG	☐ LEFT LEG	DATE: _____
☐ LASER	☐ RIGHT LEG	☐ LEFT LEG	DATE: _____
☐ SCLEROTHERAPY	☐ RIGHT LEG	☐ LEFT LEG	DATE: _____

☐ OTHER: _____

WHAT WERE YOUR RESULTS: _____

_____

_____

DO YOU HAVE A HISTORY OF?

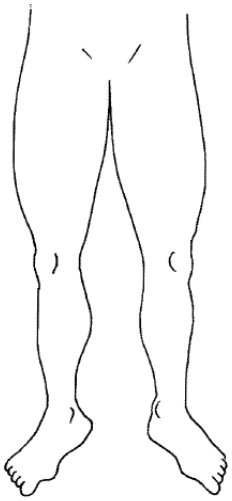
☐ DEEP VEIN BLOOD CLOTS	☐ DIABETES	☐ POOR WOUND HEALING
☐ EASY BLEEDING OR BRUISING	☐ CHRONIC PELVIC PAIN	☐ HEART DISEASE
☐ KIDNEY DISEASE	☐ LIVER DISEASE	☐ LUNG DISEASE
☐ PROBLEMS WITH ANESTHESIA	☐ PROBLEMS WITH SEDATION	

IN THE PAST SIX MONTHS HAVE YOU EXPERIENCED?

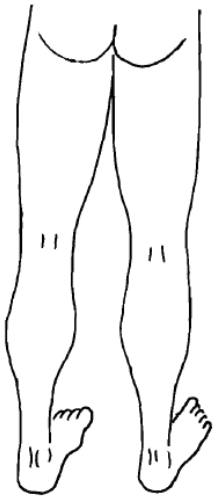
☐ UNEXPLAINED WEIGHT LOSS	☐ EXCESSIVE FATIGUE	☐ CHANGES IN SPEECH
☐ VISION CHANGES	☐ HEARING CHANGES	☐ DIZZINESS
☐ ARM OR LEG WEAKNESS	☐ ARM OR LEG NUMBNESS	☐ DIFFICULTY WALKING
☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ PALPITATIONS
☐ IRREGULAR HEART BEAT	☐ FEVER	☐ COUGH
☐ SWOLLEN LYMPH NODES	☐ ABDOMINAL PAIN	☐ BLOOD IN STOOLS
☐ BLACK TARRY STOOLS	☐ BURNING OR PAINFUL URINATION	☐ BLOOD IN URINE
☐ PAIN RADIATING DOWN THE LEG	☐ CRAMPS IN LEG WHILE WALKING	

PLEASE INDICATE THE AREAS WHERE YOU ARE CURRENTLY EXPERIENCING SYMPTOMS:

FRONT:



BACK:



MEDICATIONS

LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING.

PLEASE INCLUDE OVER THE COUNTER, PRESCRIPTIONS AND VITAMINS.

NAME OF DRUG	DOSAGE	FREQUENCY

ALLERGIES

DESCRIBE ANY ALLERGIES TO MEDICATION AND THE REACTION YOU EXPERIENCE

OTHER ALLERGIES

CHECK ANY PROBLEMS THAT YOUR ARE CURRENTLY EXPERIENCING

☐HEADACHES
☐SEIZURES OR EPILEPSY
☐DIZZINESS
☐STROKE
☐FAINTING
☐PROBLEMS WITH SPEECH
☐WEAKNESS IN ARMS OR LEGS
☐NUMBNESS IN ARMS OR LEGS
☐HEARING LOSS
☐VISUAL PROBLEMS
☐DOUBLE VISION

☐CHEST PAIN
☐IRREGULAR HEART BEAT
☐CONGESTIVE HEART FAILURE
☐PNEUMONIA
☐ASTHMA
☐SHORTNESS OF BREATH
☐BRONCHITIS
☐EMPHYSEMA
☐BLOOD IN THE SPUTUM
☐TUBERCULOSIS
☐VALLEY FEVER

☐SWALLOWING PROBLEMS
☐NAUSEA OR VOMITING
☐HEART BURN/INDIGESTION
☐BLOOD IN STOOLS
☐BLACK BOWEL MOVEMENTS
☐HIATAL HERNIA
☐STOMACH ULCERS
☐HEPATITIS OR LIVER PROBLEMS
☐GALLSTONES
☐UNEXPECTED WEIGHT LOSS
☐CANCER

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PERMISSION TO DISCUSS MEDICAL INFORMATION

Do you authorize Vascular and Interventional Physicians & Medical Diagnostic Imaging Group to discuss your care and treatment with any party beside yourself? ☐NO ☐YES

Name_____Relationship_____Number_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Medical Diagnostic Imaging Group

Attn: Privacy Officer

P.O. Box 17049

Phoenix, AZ 85011

CONSENT TO LEAVING PHI ON TELEPHONE MESSAGING SERVICES

At the discretion of Medical Diagnostic Imaging Group & Vascular and Interventional Physicians, its employees, medical staff, and agents (MDIG & VIP) and upon your agreement to the terms outlined within this consent form, you authorize (MDIG & VIP) to leave protected health information (PHI) on voice mail or other telephone messaging services. These messages may contain your personal health information such as test results and medication changes. If you authorize this, you should be aware that voice mail and other telephone messaging services are not secure or private, and such, unauthorized people may be able to retrieve and hear such communications.

I understand that information used to or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. By signing this form, I authorize you to disclose the protected health information described above.

Patient Name_____Date of Birth_____

Signature_____Date_____

Relationship to patient_____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Original to be maintained in patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (Parent, legal guardian, personal representative, etc)