

# Dr. Nelson's Venous Health History

## A. Venous Health History Form

Patient please complete questions 1-12

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Directions: Please answer the following questions. Provide estimates for date of occurrence.

### Past Medical History

1. Have you ever had vein stripping surgery  Yes  No  
If yes, when and which leg? \_\_\_\_\_
2. Have you ever had vein injections?  Yes  No  
If yes, which leg and where on the leg? \_\_\_\_\_
3. Have you ever had a blood clot?  Yes  No  
If yes, which leg and when? \_\_\_\_\_
4. Have you ever had phlebitis?  Yes  No  
If yes, which leg and when? \_\_\_\_\_

### Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Father     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

1. Do you experience any of the following in your legs?

Aching/pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Heaviness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Tiredness/fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Itching/burning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Swollen ankles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Leg cramps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Restless legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Throbbing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> One leg	<input type="checkbox"/> Both legs
Other? _____				
2. Have your veins gotten worse in recent months?  Yes  No  
Describe: \_\_\_\_\_
3. Do you take any medication for pain (i.e., Advil, Motrin)  Yes  No  
If yes, what medication do you take and how many times/mgs per day? \_\_\_\_\_
4. Do you elevate your legs to relieve discomfort?  Yes  No  
If yes, how long per day do you elevate and does it provide relief? \_\_\_\_\_

**Venous Health History Form (cont.)**

5. Do you exercise?  Yes  No  
If yes, what kind of exercise and how often? \_\_\_\_\_

6. Do you wear prescription compression stockings?  Yes  No  
**If yes, what type and gradient? How long have you worn them?** \_\_\_\_\_  
\_\_\_\_\_

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? \_\_\_\_\_

7. Do you wear light support hose (i.e., Sheer Energy)?  Yes  No  
If yes, do they provide relief?  Yes  No

8. Do you have any problem walking?  Yes  No  
If yes, describe how it interferes with your activities of daily living, which activities? \_\_\_\_\_  
\_\_\_\_\_

9. What type of work do you do? \_\_\_\_\_  
How long do you stand (hours per day) at work? \_\_\_\_\_ At home? \_\_\_\_\_  
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: \_\_\_\_\_  
\_\_\_\_\_

10. Have you ever had any test(s) done on your veins?  Yes  No  
If yes, when and what type of test and where on the leg? \_\_\_\_\_  
\_\_\_\_\_

11. Were you diagnosed with saphenous vein reflux?  Yes  No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENTS: Please stop here. The physician may go over additional questions with you.**

PHYSICIAN TO COMPLETE BELOW THIS POINT: B-F sections

**B. Initial Physician Evaluation**

**Date of Initial Physician Evaluation:** \_\_\_\_\_

Check all that apply:

- Reviewed Venous history  Physical examination of the affected leg(s)  Edema severity test completed
- Duplex or Doppler Scan order of the affected leg(s)
- Graduated, elasticized compression stockings (30-40 mmHg), **prescribed by a physician not in our practice**, have been used by the patient for at least 90 days.
- Prescription for graduated, elasticized compression stockings given to patient.
  - Today  Given at an earlier date (specify date): length of time to be wore \_\_\_\_\_
- Standing Photos taken of leg(s)  Front  Back  Front and back
- Clinical notes received from referring physician  Other causes of patient's leg(s) symptoms have been ruled out
- Instruction given on medication dosage  Instruction given on daily leg elevation
- Instruction given for mild exercise  Instruction given for weight reduction

**C. Re-evaluation Visit**

**C. Date of Physician Reevaluation:** \_\_\_\_\_

*(To review results of trial of conservative therapy-lasting at least 3-6 months):*

Patient is symptomatic with varicosities despite compliance with conservative therapy. Has failed conservative treatment.

**Check all that apply:**

- Other causes of patient's leg(s) symptoms have been ruled out
- Completed conservative treatment to include: compression stockings, medication, leg elevation, mild exercise & weight reduction (as appropriate). Time length of conservative treatment:: \_\_\_\_\_

Patient is symptomatic with varicosities causing the following: (check all that apply):

- Has persistent aching, cramping, burning, pain, itching, and/or swelling during activity or after prolonged standing.
- Significant, recurrent superficial phlebitis
- Hemorrhage from a ruptured varix
- Non-healing skin ulceration of the leg
- Other complications associated: \_\_\_\_\_

Duplex or Doppler Ultrasound of the venous system demonstrate:

- Absence of deep venous thrombosis
- Greater and/or lesser saphenous vein or perforator valvular incompetence/reflux that correlates with patients symptoms
- Perforator valvular incompetence/reflux that correlates with patients symptoms

**Re-evaluation physician signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician Additional Comments: \_\_\_\_\_

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### D. CEAP Classification (Vein Classes)

*Source: Venous Digest, Volume 12, Number 3 www.venousdigest.com March 2005*

- **Clinical Classification**
  - A classification system for visible and palpable signs of venous disease
  - Does not assess or classify subjective symptoms such as leg pain, aching, heaviness, etc.
- **Etiology** ( congenital, primary, secondary)
- **Anatomy** (superficial, deep, or perforator, etc. alone or in combination)
- **Pathophysiology dysfunction** ( reflux or obstruction, alone or in combination)

#### **CEAP Clinical Classifications:**

##### **(C) Class**

- 0-** Asymptomatic. No visible or palpable signs of venous disease
- 1 -** Spider veins, reticular veins, Telangiectasias
- 2 -** Varicose veins
- 3 -** Edema
- 4 -** Skin changes
- 5 -** Healed ulcer
- 6 -** Active ulcer



**Class 2**

**Class 3**

**Class 4-5**

**Class 6**

(E) Etiology: Congenital  Primary Disease  Secondary Disease

(A) Anatomic Findings: Alone/ in combination –Superficial  Deep  Perforator

(P) Pathophysiology Dysfunction: Reflux  Obstruction  Both Reflux & Obstruction

Physician Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Disclaimer:** The medical criteria guidelines listed below are for training purposes only. The information was obtained from the payors website which lists medical policy guidelines for treatment of varicose veins. VNUS Medical Technologies, Inc. recommends that medical service providers contact insurers/payors in their specific area to obtain the most accurate and up to date medical policy guidelines information for their reimbursement needs. This information does not constitute reimbursement or legal advice. VNUS Medical Technologies, Inc. makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Service providers are responsible for their decisions relating to reimbursement submissions.