Hager Advanced Vein Care
Vein History and Medical Necessity Form

Name _____ Date _____

1. Which of the following are causing you concern? (Circle all that apply)

Spider Veins **Bulging Varicose Veins** **Leg swelling**

2. How long have your veins been a problem?_____

3. Do your veins limit your daily activities due to discomfort? YES NO

4. Does prolonged sitting or standing aggravate your veins? YES NO

5. Have you ever noticed any of the following occur during activity or after prolonged standing? (Circle all that apply)

Aching **Fatigue** **Swelling** **Itching** **Pain** **Burning**

Exercise intolerance **Feeling of heaviness** **Skin changes**

6. Have you ever had any of the following? (Circle all that apply)

Bleeding from a spider vein **Slow or non-healing skin ulceration**

Significant, recurrent superficial phlebitis **Darkening of the skin**

7. Have you ever been treated for ulcerations or a blood clot in your leg? If yes, when and which leg? What was done?

_____

_____

_____

8. Are you currently wearing compression stockings? YES NO

9. In past months or years, how have you attempted to manage your varicose vein symptoms? (circle all that apply)

Compression Stockings **Attempted weight loss** **Exercise**

Leg elevation **Medications (Motrin, Alleve, aspirin, etc.)**

10. Do you experience any of the following symptoms? (circle all that apply)

Chest pain **Shortness of Breath** **Prolonged Bleeding**
Fevers **Chronic Cough** **New onset of leg swelling**
Easy fainting

Patient's signature _____

Medical History

	Y	N		Y	N
Anxiety	☐	☐	Bleeding Problems	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐
Heart Disease	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Irregular Heartbeat	☐	☐	Migraines	☐	☐
Stroke	☐	☐	Mitral Prolapse	☐	☐
Emphysema	☐	☐	Obesity	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐
TYPE:_____			Parkinson's	☐	☐
Dementia	☐	☐	Pneumonia	☐	☐
Depression	☐	☐	Clot in Lung	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Diverticulitis	☐	☐	Sleep Apnea	☐	☐
Clot in Leg ARTERY	☐	☐	Varicose Veins	☐	☐
Clot in Leg VEIN	☐	☐	Thyroid Disorder	☐	☐
Acid Reflux	☐	☐	Mini-stroke	☐	☐
Glaucoma	☐	☐	Trouble w/ anesthesia	☐	☐
HIV	☐	☐	Circulation Problem	☐	☐
Hepatitis	☐	☐			

Surgical History

	Y	N		Y	N
Appendix	☐	☐	Pacemaker	☐	☐
Bariatric	☐	☐	Pilonidal Cyst	☐	☐
Breast	☐	☐	Hysterectomy	☐	☐
Heart	☐	☐	Orthopedic	☐	☐
C-Section	☐	☐	Spinal	☐	☐
Gall Bladder	☐	☐	Tubal Ligation	☐	☐
Colonoscopy	☐	☐	Chest	☐	☐
Fractures	☐	☐	Thyroid	☐	☐
Stomach/Intestines	☐	☐	Tonsils	☐	☐
Hemorrhoid	☐	☐	Prostate	☐	☐
Hernia	☐	☐	Circulation	☐	☐
			Other: _____		

ALLERGIES: _____

DATE: _____

ACCOUNT: _____

List All Medications with dose, including Over-The-Counter

_____

_____

_____

_____

_____

Current Every Day Smoker ☐
Current Some Day Smoker ☐
Former Smoker ☐
Never A Smoker ☐

If a smoker: How Much? _____ppd
How Long? _____

HEIGHT: _____

WEIGHT: _____

BLOOD PRESSURE: _____/_____

PHARMACY:

Name: _____

Location: _____

Phone Number: _____

Family History (People **OTHER THAN YOU** who have/had the following)

Diagnosis			Which Family Members had the disease ?
Breast Cancer	□Y	□N	_____
Cervical Cancer	□Y	□N	_____
Colon Cancer	□Y	□N	_____
Lung Cancer	□Y	□N	_____
Ovarian Cancer	□Y	□N	_____
Prostate Cancer	□Y	□N	_____
Skin Cancer	□Y	□N	_____
Heart Disease	□Y	□N	_____
Stroke	□Y	□N	_____
Hypertension	□Y	□N	_____
Diabetes	□Y	□N	_____
Thyroid Disorders	□Y	□N	_____
Alcoholism	□Y	□N	_____
Arthritis	□Y	□N	_____
Asthma	□Y	□N	_____
Bleeding disorder	□Y	□N	_____
Depression	□Y	□N	_____
Hyperlipidemia	□Y	□N	_____
Migraines	□Y	□N	_____
Kidney/Renal disease	□Y	□N	_____
Suicide	□Y	□N	_____

Other: _____

None of the above is applicable: _____ (initial)

Account: _____ Date: _____