10224 Durant Rd Suite 109
Raleigh, NC 27614
(919)844-4444

Name: (Mr. Mrs. Ms. Dr.)_____

Street Address:_____

City:_____ State:_____ Zip Code::_____

Date of Birth:_____ Social Security #:_____

Driver's License #:_____ State Issued:_____

How may we contact you?

Home Phone: _____ Cell Phone: _____

Email:_____ Other:___ _____

Emergency Contact Name & Phone number: _____

Where may we mail your statements? _____

How did you hear about us? _____

PRIMARY INSURANCE:

Insurance Company:_____

Employer:_____

ID#_____

Group #_____

Relationship to Insured:_____

If not self, provide the **POLICY HOLDER'S** information:

Insured's Name:_____

Insured's DOB:_____

Insured's SS#:_____

Employer:_____

SECONDARY INSURANCE:

Insurance Company:_____

Employer:_____

ID#_____

Group #_____

Relationship to Insured:_____

If not self, provide the **POLICY HOLDER'S** information:

Insured's Name:_____

Insured's DOB:_____

Insured's SS#:_____

Employer:_____

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VEIN HISTORY

When did you first notice your enlarged or discolored veins? _____

Have you ever had any of the following? Please check and explain:

_____Family history of vein problems? _____
_____Prior varicose vein treatment or surgery?_____
_____Prior Spider vein treatment including Sclerotherapy/ Injections or surface laser?_____
_____Pelvic varicosities/ Hemorrhoids? _____
_____Phlebitis?_____
_____Blood clot? _____
_____Vein rupture? _____
_____Venous Ulcer?_____
_____Factor V Leiden or other genetic conditions related to veins?_____
_____Trauma to legs? _____

SYMPTOMS:

*****Insurance coverage is only applicable when veins are causing symptoms and impacting your daily life. Please provide detailed information regarding your symptoms below******

Circle the symptoms that apply to you, *Circle* which leg: right, left, both , list the *location* of your symptoms.

____Swelling? Left Right Both Where? _____
____Intense / Severe Pain- Left Right Both Where? _____
____Moderate Pain- Left Right Both Where? _____
____Mild Pain/ Dull Pain? Left Right Both Where? _____
____Throbbing/ Aching Pain? Left Right Both? Where? _____
____Itching/ Burning/ Tingling? Left Right Both? Where? _____
____Numbness/ Decreased Sensation? Left Right Both? _____
____Discoloration? Left Right Both? Where? _____
____Restlessness? Left Right Both? Where? _____
____Other? Left Right Both? _____

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ACTIVITIES OF DAILY LIVING:

What factors bring on your symptoms?(ex: standing more than 15 minutes, walking, hot temperatures, hot baths, pressure applied to areas of your legs, working, exercising, cooking, grocery shopping)_____

_____

_____

Do you have swelling after prolonged standing? YES / NO

Do symptoms interfere with activities of daily living? YES / NO

Describe how these symptoms have affected your lifestyle and daily activities: (ex: Unable to stand to prepare meals, unable to exercise, can not walk around store to shop with out sitting and resting…)_____

_____

_____

Employed: YES / NO Occupation:_____

Do symptoms impact your ability to perform job related tasks? Explain: _____

_____

Social Habits:
Do you drink alcoholic beverages? Yes / No (*#/week* _____)

Exercise ? Yes / No (*#of days / week* _____, What type of exercise?_____

Do you use tobacco products? Yes / No (*Packs/week* _____) *Q*uit Date, if applicable _____

CONSERVATIVE THERAPY:

Has you ever been seen by and had a doctor prescribe conservative therapy for vein problems?

_____Compression stockings?

_____Daily Walking or Exercise?

_____Leg elevation?

_____Weight reduction?

_____Medication for vein/leg discomfort? (ex: Tylenol, Ibuprofen, Prescription pain medication)

_____Avoidance of excessive temperatures? (ex: hot baths, saunas, hot tubs)

If yes to any above, who was the Prescribing Dr, and when were measures advised? _____

_____

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MEDICAL HISTORY:

Medical Conditions(Past & Current):

ALL Surgeries & Dates:

ALL Allergies and sensitivities:

CURRENT Medications: (Prescribed and over the counter) (Dosage, How Often Taken)

If you are female, are you currently pregnant? Yes/ No / Unsure

Are you planning pregnancy in the next 6 months? Yes/ No

Number of previous pregnancies? _____

Number of previous Live births?_____