Southern Arizona Laser & Vein Institute
6422 East Speedway Boulevard - Suite 150 - Tucson, Arizona 85710
Phone: (520) 318-3004 Fax: (520) 318-3061 www.SALVI-Tucson.com

A MESSAGE ABOUT OUR PATIENT HISTORY FORM

Dear Patients,

Thank you in advance for taking the time to accurately complete our SALVI patient questionnaire. This valuable tool helps us to help you. Due to increasingly stringent and severe insurance company regulations, we are required to submit all of this information to your insurance company prior to scheduling any treatments. Many insurance carriers now require digital photographs as well.

For your information, most insurance companies **REQUIRE** that Grade 2 (30 -40 mmHg) compression stockings be worn *prior* to approving any treatments, and that the stockings are beneficial in symptomatic improvement. The duration of wear ranges from 2 weeks to 3 months. Also, many insurance companies **REQUIRE** that you have documented "functional Impairment" such as skin ulcers, phlebitis, bleeding, stasis dermatitis **or** moderate to severe pain (grade 2 or 3 on functional pain questionnaire) *prior* to approving any treatments.

We at SALVI apologize for the burden of completing these forms and complying with these requirements. THESE ARE NOT OUR RULES. We hope you understand that we cannot supersede or overrule insurance company requirements. If we were to try to proceed with treatment prior to documenting completion of all requirements, your insurance company would NOT pay for the service and the bill would be your responsibility.

Thank you for being loyal and understanding patients. We are working hard for you and hope to achieve the excellent results we strive for and you deserve.

Sincerely,

Michael R. Probstfeld, M.D., FACS
Southern Arizona Laser & Vein Institute

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FUNCTIONAL PAIN QUESTIONNAIRE

1) **Do you perform daily activities which require prolonged periods of standing? Yes No**

   If YES, please explain further:

   What activities require prolonged periods of standing?

   _____

   _____

   How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities?

   a. Never (0)
   b. Once per day (1)
   c. 2 – 3 times per day (2)
   d. 4 or more times per day (3)

2) **Do you take over-the-counter medications (e.g., aspirin, ibuprofen, NSAIDS, or a similar type of medication) or prescription medications for aching, cramping, burning or swelling of the lower extremities? Yes No**

   If YES, please explain further:

   What is the medication and dosage?

   _____

   _____

   How many days in an average **two week period** of time do you take the medication?

   a. 0 – 2 days (0)
   b. 3 – 4 days (1)
   c. 5 – 6 days (2)
   d. 7 or more days (3)

3) **Have you worn compression stockings for at least 2 weeks for your symptoms? Yes No**

   If YES, please explain further:

   What strength (in mmHg) were the stockings? 20 – 30 30 – 40 Other: _____

   Did the stockings result in significant improvement in symptoms? Yes No

   _____

SCALE: 0 = no symptoms 1 = mild 2 = moderate 3 = severe

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PATIENT HISTORY FORM

PLEASE MARK ALL QUESTIONS AS INDICATED

Date: _____ Last Name:_____ First Name: _____

Date of Birth: _____ Sex: Male Female Height: _____ Weight: _____

Do you have varicose veins: Yes No If yes, which leg is affected: Right Left Both

What are your symptoms (circle all that apply):

Pain Swelling Aching Fatigue Heaviness

Discoloration Ulcers Bleeding Other: _____

How long have you had varicose vein problems? _____

Are your symptoms getting worse? Yes No

Note: Your insurance company probably will not approve your treatment if Compression stockings have NOT been worn for at least three (3) months.

Have you worn compression stockings? Yes No Type: _____ How long: _____

Does walking or exercise relieve your symptoms? Yes No

Have you had any previous treatment? Yes No

If yes, what types of treatments have you had (circle all that apply):

Injections	Right	Left
Avulsion Phlebectomy	Right	Left
Stripping	Right	Left
Radiofrequency Closure	Right	Left
Laser Ablation	Right	Left
Laser for Spider Veins	Right	Left

Have you ever had blood clots? Yes No

Have you had any tests on your veins? Yes No

If yes, what types of tests have you had (circle all that apply):

Ultrasound / Duplex	Right	Left
X-rays	Right	Left
Venogram	Right	Left

THE FOLLOWING INFORMATION IS IMPORTANT FOR INSURANCE COVERAGE OF TREATMENT

Have you used any medications to treat your vein symptoms? **Yes** **No**

If yes , circle all medications that apply: Aspirin Ibuprofen Advil Tylenol Narcotic Analgesics Venostat

Herbals Creams Others: _____

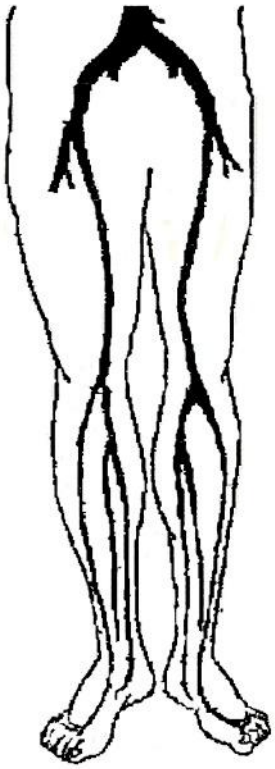
What are your goals for treatment of your veins (circle all that apply):

Relieve Pain Prevent Complications Decrease Swelling Work more comfortable

Treat existing ulceration or bleeding Enjoy recreational activities more Improve my appearance

Other: _____

On the diagram below, please indicate where your problem veins are located:



Does anyone in your family have varicose vein problems? Yes No

Have you had any pregnancies? Yes No If Yes, How many? _____

Any pregnancies planned in the future? Yes No

GENERAL MEDICAL HISTORY

Please indicate all allergies and the type of reaction: _____

_____

_____

_____

Please list all medications and strengths: _____

_____

_____

_____

Please list any prior operations with approximate dates: _____

_____

_____

_____

MEDICAL CONDITIONS MUST BE INDICATED (Please circle all that apply)

Diabetes	Patient Foramen Ovale	Heart Disease	Heart Attack	Valley Fever
Atrial Septal Defect	Pneumonia	High Blood Pressure	Stroke	Kidney Disease
Epilepsy or Seizures	Cancer or Leukemia	Hepatitis (type): _____		
Lung Disease:	Emphysema	COPD	Asthma	TB
G.I. Disease:	Diverticulosis	Crohns Disease	Ulcerative Colitis	Ulcers
Phlebitis	Macular Degeneration	Glaucoma	Anemia or low white blood cells or platelets	
Migraine Headaches	Thyroid Disease	Blindness	Arthritis	HIV
Mitral Valve Prolapse	Mental Illness	Trauma to your legs	Restless Leg Syndrome	

SOCIAL HISTORY

Do you smoke: Yes No How long: _____ Amount per day: _____

Do you drink alcohol Yes No Drinks per day _____ or per week _____

Do you use drugs Yes No Marital Status: Married Single Divorced Widowed

Type of Work: _____ Number of hours per day on your feet: _____

How did you hear about SALVI / Dr. Probstfeld: _____

Primary Care Physician: _____