

Shoreline Vein Clinic & Medical Spa

4-1 Huntley Road • Old Lyme, CT • 06371

Patient Questionnaire

Name: _____

Date: _____

Date of Birth: _____

Please complete the following questionnaire to the best of your knowledge and with the understanding that this will be used not only to assist the Doctor in diagnosing you but by your insurance company (if needed). Please be advised that this form will be used in conjunction with the Doctor's notes and other required studies by the insurance companies when preauthorization is needed for surgery.

Reason for today's visit: _____

I have experienced the following:

Severe and/or Persistent Pain, Cramping, and/or Burning: **Y N**

How Long: _____ Where: _____

Factors that worsen symptoms: _____

Pain Alleviating Factors: _____

Severe and/or Persistent Swelling: **Y N**

How Long: _____ Where: _____

Factors that worsen symptoms: _____

Pain Alleviating Factors: _____

Severe Skin Pigmentation: **Y N**

How Long: _____ Where: _____

History of Superficial Thrombophlebitis: **Y N**

How Long: _____ Where: _____

Skin Ulcerations: **Y N**

For How Long: _____ Where: _____

Have you tried any of the following to help in alleviating the above mentioned symptoms:

Compression Stockings: **Y** **N**

How Long: _____ What Compression: 15/20 20/30 30/40

Prescribed by: _____

Analgesics: **Y** **N**

What/How Much: _____ For How Long: _____

Prescribed by: _____

Weight Loss: **Y** **N**

Leg Elevation: **Y** **N**

Avoidance of Prolonged Standing: **Y** **N**

Exercise Regime: **Y** **N**

I _____, have completed the above information on to the best of my knowledge.

Patient Signature: _____

Date: _____

Additional Comments Made by Physician:
