



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



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

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



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

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

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: _____