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FOLLOW-UP POST-VENOUS TREATMENT

PATIENT NAME ____ DATE______________________

PLEASE COMPLETE THE FOLLOWING INFORMATION AS IT APPLIES SINCE YOUR LAST VISIT HERE.

1. Have you been wearing your support stockings as prescribed by Dr. Brazil? ☐ Yes ☐ No
   If No, explain why not ____
2. Have you been elevating your legs higher than your heart for one hour three times daily every day?
   ☐ Yes ☐ No If No, explain why not ____
3. Have you been active, walking and/or continuing your exercise program? ☐ Yes ☐ No
   If No, explain why not ____
4. Have you had any change in your weight since your last visit?
   ☐ No Change ☐ Loss (How Much?) _____________ ☐ Gain (How Much?) ___________

PLEASE INDICATE YOUR RESPONSE TO TREATMENT

***Note**: Indication of pain level is based on a scale of 1 to 10 with 1 the lowest (no pain) and 10 the highest (severe).

1. Are you continuing to have pain/discomfort while wearing your support stockings?
   ☐ Yes ☐ No If Yes, where? ____ * Level _________
2. Do you have pain when you take your stockings off at night and the veins start to expand?
   ☐ Yes ☐ No If Yes, where? ____ * Level _________
3. Is this pain so severe that you have to take pain medication?
   ☐ Yes ☐ No If Yes: Medication ___________________________ Dosage _______ Frequency ______
4. If you continue to have pain/discomfort, is it better than before treatment?
   ☐ Yes ☐ No If Yes, how much better? ___________ % or * Level ___________
5. Do you continue to have swelling?
   ☐ Yes ☐ No If Yes, where? ____
6. If you continue to have swelling, indicate when this occurs:
   ☐ As soon as I am on my feet and legs ☐ After I am up for _______ hours ☐ Not until late in the day
7. Do you take pain medication?
   ☐ Yes ☐ No If Yes: Medication ___________________________ Dosage _______ Frequency ______

Do you have other concerns or questions about your progress and continued treatment? Again, we remind you these are the things that Medicare and other insurance require we try before they will approve any procedure or surgery. ____

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(Please use the back of the page if needed.)

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PATIENT SIGNATURE DATE