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PATIENT PREOP DOCUMENTATION of VENOUS CONSERVATIVE THERAPY

Name: _____

Today's Date _____ Date Conservative Therapy Started: _____

Since my previous visit, I have followed conservative treatment measures including the following with the indicated response to conservative therapy: (check all that apply)

☐ Wearing gradient compression hose of _____ mmHg
☐ Thigh-high ☐ Knee-high ☐ Daily ☐ P.R.N.
☐ Avoidance of hot baths, saunas, hot tubs, (other _____)
☐ Elevation of legs higher than heart level for pain relief _____ Min / Hr _____ times daily.
☐ Elevation of legs at night—bed raised or pillows under feet
☐ Taking pain medication: What medication? _____ Dosage _____
How often needed? _____ _____
☐ Unresolved/Increasing pain and discomfort, i.e. persistent leg pain that interferes with daily living
☐ Pain after taking off support stockings at night that usually lasts for _____ Min / Hr
☐ Patient's pain scale: 0 = None 10 = Worst Score: _____
Other **SPECIFIC** changes in daily activities: _____

_____

PERSISTENT SYMPTOMS: (Check all that apply)

R	L		R	L		R	L	
☐	☐	Leg Pain	☐	☐	Tired/Heavy Legs	☐	☐	Skin Changes
☐	☐	Tenderness	☐	☐	Leg Cramps	☐	☐	Red/Warm Areas
☐	☐	Aching/Throbbing	☐	☐	Itching	☐	☐	Ulcers/Ulceration
☐	☐	Burning/Stinging	☐	☐	Swelling	☐	☐	None
						☐	☐	Other: _____

_____

Patient Signature: _____

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PHYSICAL EXAMINATION: Varicose veins ☐ R ☐ L Edema ☐ R ☐ L Skin Changes ☐ R ☐ L Other _____

Compared to Previous Visit: Unchanged ☐ R ☐ L Changed ☐ R ☐ L (Specify Change) _____

_____

_____

Impressions: ☐ Varicose Vein Disease, Symptomatic with Conservative Therapy
☐ Varicose Vein Disease, Asymptomatic with Conservative Therapy

Recommendations:
☐ Proceed with plans for definitive surgical treatment
☐ Continue with conservative treatment for now and re-evaluate in _____ months
☐ Other _____

Physician Signature: _____