PATIENT INFORMATION

PLEASE VERIFY ALL INFORMATION BELOW IS CORRECT

Patient name:		Phone (Home):	
Patient SSN: (Required)	**(required for insurance purposes)** Please put SSN here: _____-_____-_____	Phone (Work):	
Address:		Phone (Cell):	
City/State/Zip:		Email:	
Marital Status:		Occupation:	

Gender: ❑ F ❑ M	Date of Birth:	Preferred Contact: ❑Cell Phone ❑Home Phone ❑ Work Phone ❑Email

Emergency Contact:	Relationship to Patient:	Emergency Contact Phone: (Work / Home)

Race: ❑ American Indian ❑ Asian ❑ Black/African American ❑ Native Hawaiian /Other Pacific Islander ❑ White ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Referring Physician Phone Number::		Primary Care Physician: Phone Number:		How did you Hear about Us?	

Name of Primary Insurance Company:_____

Is the above Primary Insurance Policy in your name? Yes ☐ No ☐

If the policy is not in your name please complete the following information:

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____(**required for insurance purposes**)

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Name of Secondary Insurance Company:_____

Is the above Secondary Insurance Policy in your name? Yes ☐ No ☐

If the policy is not in your name please complete the following information:

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____(**required for insurance purposes**)

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Please tell us why you are here:_____

May we send a report of our findings, recommendations findings to your family doctor? Yes ☐ No ☐

Please check in the box if any of the following conditions were present in you.

	You			You	
	Yes	No		Yes	No
No contributing Family History	☐	☐	Herb Medication	☐	☐
Abnormal Bleeding	☐	☐	High Blood Pressure	☐	☐
Autoimmune Disorders	☐	☐	Kidney Disease	☐	☐
Cancer – What type?	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Lung Disease	☐	☐
Endocrine Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Heart Disease	☐	☐	MRSA	☐	☐
Hemophilia	☐	☐	Von Willebrand	☐	☐

	You				Family			
LEG VEIN HISTORY	Right	Left	Both	Neither	Right	Left	Both	Neither
Operation or Casting	☐	☐	☐	☐				
Deep Vein Thrombosis (Blood Clot)	☐	☐	☐	☐	☐	☐	☐	☐
Phlebitis	☐	☐	☐	☐	☐	☐	☐	☐
Venous Stasis Ulcer	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding From Varicose Vein	☐	☐	☐	☐	☐	☐	☐	☐
Sclerotherapy	☐	☐	☐	☐	☐	☐	☐	☐
Vein Stripping	☐	☐	☐	☐	☐	☐	☐	☐
Previous Vein Ablation	☐	☐	☐	☐	☐	☐	☐	☐

Please list any Current Medications you are taking and dosage information:

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	

Are you currently on any of these medications (Please check Yes or No and any Details):

	Yes	**No**	**Details**
Coumadin	☐	☐	
Eliquis	☐	☐	
Plavix	☐	☐	
Daily Aspirin	☐	☐	
Xarelto	☐	☐	
Antibiotics	☐	☐	
Steroids	☐	☐	

Please list any and all allergies and reactions:

1	
2	
3	
4	
5	
6	
7	
8	

Past Surgical History / Hospitalizations

	Surgery / Hospitalization	Date	Anesthesia Complications	Notes
1				
2				
3				
4				
5				

Social History

Patient Height _____

Patient Weight _____

	Yes	No		Length of Time of Use	Length of Time of Quit
Alcohol	☐	☐			
Illegal Drugs	☐	☐			
High Risk Factors	☐	☐			
HIV / Hepatitis	☐	☐			
Tobacco Smokeless	☐	☐			
Tobacco Smoker	☐	☐	Packs per Day _____		

Have you received the flu vaccine within the past year? Yes ☐ No ☐

Have you received the pneumonia vaccine within the past 3 years? Yes ☐ No ☐

Have you had a colonoscopy? Yes ☐ No ☐

Have you been screened for osteoporosis? Yes ☐ No ☐

For Women Only

	Yes	No	Details
Are you pregnant or think you might be?	☐	☐	
Are you currently nursing (breast feeding)?	☐	☐	
Any recent changes in oral contraceptive use or hormone replacement therapy?	☐	☐	
Have you ever had a miscarriage? If (**Yes**) how many? _____	☐	☐	
Have you ever had a mammogram?	☐	☐	

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the nurses, or your doctor.

Lack of energy • unexplained weight gain or weight loss • loss of appetite • fever • Difficulty with hearing • sinus problems

nose bleeds • sore throat • Irregular heartbeat • racing heart • chest pains • swelling of feet or legs

pain in legs with walking • Shortness of breath • cough • oxygen at home • coughing up blood • abnormal chest x-ray

diarrhea • abdominal pain • nausea • vomiting • Painful urination • frequent urination, urgency • prostate problems

bladder problems • impotence • Joint pain • aching muscles s • swelling of joints • back pain

Persistent rash, itching, pigmentation • Frequent headaches • problems with walking or balance, dizziness

Insomnia • depression • anxiety • Intolerance to heat or cold • frequent hunger/urination/thirst

Easy bleeding • easy bruising • anemia • unexplained swollen areas • Seasonal allergies • hay fever symptoms, itching

frequent infections • exposure to HIV.

Please explain if you circled yes to any::_____

_____

_____

_____

I agree all the proceeding information is correct to the best of my knowledge. Please sign here: _____