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?	
Preferred Pharmacy: Phone Number:					

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		Family			You		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Abnormal Bleeding	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Autoimmune Disorders	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐
Cancer – What type?	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Lung Disease	☐	☐	☐	☐
Endocrine Disease	☐	☐	☐	☐	MRSA	☐	☐	☐	☐
Heart Disease (Ablation, PFO, Mitral Valve Prolapse, A-Fib, Stents, etc.)	☐	☐	☐	☐	Neurogical (CVA,TIA,Seizures, etc.)	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐	Sleep Apnea	☐	☐	☐	☐
Herb Medication	☐	☐	☐	☐	Von Willebrand	☐	☐	☐	☐
	☐	☐	☐	☐		☐	☐	☐	☐
If yes, Please provide Additional Information									

	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	☐	☐	☐	☐	☐	☐	☐	☐
If yes, Please provide Additional Information								

Pain Management Information, Please give reason: _____

Physician:	**Physician Number:**

Please list any Current Medications you are taking with dosage and frequency information: **Reasons for Taking Medication**

1		
2		
3		
4		
5		
6		
7		
8		

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

	Yes	**No**	**Details and Frequency**
Coumadin	☐	☐	
Eliquis	☐	☐	
Plavix	☐	☐	
Daily Aspirin	☐	☐	
Xarelto	☐	☐	
Antibiotics	☐	☐	
Steroids	☐	☐	
Diet Pills	☐	☐	

Please list any and all allergies and reactions:

Latex Allergy ? Yes ☐ **No** ☐	
1	
2	
3	
4	
5	
6	
7	

Past Surgical History / Hospitalizations

	Surgery / Hospitalization	Date	Anesthesia Complications	Notes
1				
2				
3				
4				

Social History

Patient Height _____

Patient Weight _____

	Yes	No		Length of Time of Use	Length of Time of Quit
Alcohol	☐	☐	**Drinks Per Week** _____		
Illegal Drugs	☐	☐	**Please Explain ?**		
High Risk Factors	☐	☐	**Please Explain ?**		
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	☐	☐	
On 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 CHECK 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.

	N	Y	DETAILS
CONSTITUTIONAL			
Lack of energy			
Unexplained weight loss or gain			
Fever			
Night sweats			
ENT			
Difficulty hearing			
Sinus problems			
Nosebleeds			
Sore throat			
CARDIOVASCULAR			
Irregular heartbeat			
Racing heart			
Chest pains			
Swelling of feet or legs			
Pain in legs when walking			
RESPIRATORY			
Shortness of breath			
Prolonged cough			
Oxygen at home			
Abnormal chest x-ray			
Coughing up blood			
GI			
Nausea			
Vomiting			
Abdominal pain			
Diarrhea			

	N	Y	DETAILS
MS			
Joint paint			
Aching Muscles			
Swelling of joints			
Back pain			
SKIN			
Itchy			
Rash			
Pigmentation of legs			
NEURO			
Frequent headaches			
Dizziness			
Problems with walking or balance			
PHYCHIATRIC			
Depression			
Insomnia			
Anxiety			
ENDOCRINOLOGY			
Intolerance to heat or cold			
Frequent hunger/urination/thirst			
HEMATOLOGIC			
Easy bleeding			
Easy bruising			
Anemia			
Unexplained swollen areas			
ALLERGIC			
Seasonal allergies			
Hay fever symptoms			
Exposure to HIV			
Hepatitis C positive			

Please explain if you checked yes to any::_____

_____

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