

PATIENT INFORMATION

DATE _____ HOME PHONE _____ CELL PHONE _____
 NAME (First) _____ (MI) _____ (Last) _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 BIRTHDATE _____ SEX: Male Female MARITAL STATUS: S M D W

PATIENT INFORMATION

SPOUSE INFORMATION

Occupation:	Name:
Work Phone:	Occupation:
Employer:	Work Phone:
City, State:	Employer:
Social Security Number:	City, State:
Email Address:	Social Security Number:
	Date of Birth:

How did you find out about us?

Radio _____ (station) TV _____ (station) Newspaper _____ (name) Magazine _____ (name) Internet
 Friend/Family Member _____ Physician Referral* Other _____

*Physician who referred you:

Address _____ City _____ State _____ Zip _____
 Specialty _____ Phone: _____

P C P	Primary Care Physician: _____ Address _____ City _____ State _____ Zip _____ Specialty _____ Phone _____
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For Women

O B G Y N	Primary Care Physician: _____ Address _____ City _____ State _____ Zip _____ Phone _____
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INSURANCE INFORMATION

Primary _____ Group/ ID# _____ Insured's Name _____
 Secondary _____ Group/ ID# _____ Insured's Name _____

C O N T A C T	IN CASE OF EMERGENCY, CONTACT: 1. _____ Relation _____ Phone _____ 2. _____ Relation _____ Phone _____
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I authorize Goldman Vein Institute to execute any documents necessary, and release to my health insurance carrier and/or primary treating physicians, or other organizations as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment or to provide for continuity of medical care.

Signature _____ Date _____

PATIENT HISTORY

NAME _____ AGE _____ DATE _____

Symptoms: <i>(Please check if yes)</i>	R	L	Check if you have any of the following:
Aching/Pain in Legs	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	Contagious Disease
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
Leg Cramping	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
Leg Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Leg Trauma/Surgery
Do your symptoms interfere with your sleep?	<input type="checkbox"/>		Major Surgery/Hospitalization
Do your symptoms interfere with walking?	<input type="checkbox"/>		<i>(Please list on back, if needed)</i>
Do your symptoms worsen with or after activity?	<input type="checkbox"/>		

On a scale of 1 to 10, with 10 being the worst, I consider my vein disease to be:
Slightly bothersome 1 2 3 4 5 6 7 8 9 10 Severely affecting my life

Conservative Measures Used Currently or Previously: *(Please check those measure that you have tried)*

Pain medications or herbal supplements Leg Elevation Exercise Job Change Weight Loss
 Compression Stockings or Leg Wraps *If so, how long?* _____

RLS: <i>(Please check box if yes)</i>	
Do you find the need to move your legs to relieve an uncomfortable feeling?	<input type="checkbox"/>
Do your legs feel better when moving them or after walking?	<input type="checkbox"/>
Are you legs symptoms worse when sitting or resting, without elevating legs	<input type="checkbox"/>
Are you legs symptoms worse later in the day or night.....	<input type="checkbox"/>

Woman Only: <i>(Please check box if yes)</i>	
Are you pregnant or considering a pregnancy sometime in the future?	<input type="checkbox"/>
Are you breast feeding?	<input type="checkbox"/>
Are your legs more painful associated with menstruation?	<input type="checkbox"/>
Have you ever been diagnosed with Pelvic Congestion Syndrome?	<input type="checkbox"/>
Number of pregnancies? _____ Number of deliveries? _____ Ages of Children _____	

Please list Prescription and OTC Medications: *(Please list on back, if needed)*

Please list Medical Allergies: *(Please list on back, if needed)*

Please check box if you have, or have had, any of the following:	
A prior evaluation for your veins?	<input type="checkbox"/>
Previous vein surgery or laser treatment?.....	<input type="checkbox"/>
Previous vein injections?.....	<input type="checkbox"/>
Bleeding from a vein?	<input type="checkbox"/>
A leg ulceration?	<input type="checkbox"/>
Previous vein surgery or laser treatment?.....	<input type="checkbox"/>
Phlebitis?	<input type="checkbox"/>
Any type of blood clot/clotting disorder?.....	<input type="checkbox"/>
<i>If so, were you treated with blood thinner?..</i>	<input type="checkbox"/>
A family history of vein disease?.....	<input type="checkbox"/>
A family history of leg ulceration?	<input type="checkbox"/>
A family history of blood clots?.....	<input type="checkbox"/>