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: _____

PCP

Primary Care Physician: _____

Address _____ City _____ State _____ Zip _____

Specialty _____ Phone _____

For Women

OBGYN

Primary Care Physician: _____

Address _____ City _____ State _____ Zip _____

Phone _____

INSURANCE INFORMATION

Primary _____ Group/ ID#_____ Insured's Name_____

Secondary _____ Group/ ID#_____ Insured's Name_____

CONTACT

IN CASE OF EMERGENCY, CONTACT:

1. _____ Relation _____ Phone _____
2. _____ Relation _____ Phone _____

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: (*Please check if yes*)	R	L
Aching/Pain in Legs	❑	❑
Heaviness	❑	❑
Itching/Burning	❑	❑
Leg Cramping	❑	❑
Leg Restlessness	❑	❑
Throbbing	❑	❑
Swelling	❑	❑

Do your symptoms interfere with your sleep? ❑
Do your symptoms interfere with walking? ❑
Do your symptoms worsen with or after activity? ❑

Check if you have any of the following:

Heart Disease ❑
Contagious Disease ❑
Hepatitis ❑
High Blood Pressure ❑
Diabetes ❑
Cancer ❑
Leg Trauma/Surgery ❑
Major Surgery/Hospitalization ❑
(*Please list on back, if needed*)

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 _____ **or**_____**:** (*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: (*Please check box if yes*)

Do you find the need to move your legs to relieve an uncomfortable feeling? ❑
Do your legs feel better when moving them or after walking? ❑
Are you legs symptoms worse when sitting or resting, without elevating legs ❑
Are you legs symptoms worse later in the day or night ❑

Woman Only: (*Please check box if yes*)

Are you pregnant or considering a pregnancy sometime in the future? ❑
Are you breast feeding? ❑ Are your legs more painful associated with menstruation? ❑
Have you ever been diagnosed with Pelvic Congestion Syndrome? ❑
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? ❑
Previous vein surgery or laser treatment? ❑
Previous vein injections? ❑
Bleeding from a vein? ❑
A leg ulceration? ❑
Previous vein surgery or laser treatment? ❑

Phlebitis? ❑
Any type of blood clot/clotting disorder? ❑
If so, were you treated with blood thinner? ❑
A family history of vein disease? ❑
A family history of leg ulceration? ❑
A family history of blood clots? ❑