

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: *(Please check if yes)*

	R	L
Aching/Pain in Legs	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Leg Cramping	<input type="checkbox"/>	<input type="checkbox"/>
Leg Restlessness	<input type="checkbox"/>	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	Phlebitis?	<input type="checkbox"/>
Previous vein surgery or laser treatment?.....	<input type="checkbox"/>	Any type of blood clot/clotting disorder?.....	<input type="checkbox"/>
Previous vein injections?.....	<input type="checkbox"/>	<i>If so, were you treated with blood thinner?..</i>	<input type="checkbox"/>
Bleeding from a vein?	<input type="checkbox"/>	A family history of vein disease?.....	<input type="checkbox"/>
A leg ulceration?	<input type="checkbox"/>	A family history of leg ulceration?	<input type="checkbox"/>
Previous vein surgery or laser treatment?.....	<input type="checkbox"/>	A family history of blood clots?.....	<input type="checkbox"/>