
Patient Name:_____ Date: _____

Address: _____

City, St, Zip _____

Primary Phone: _____ Alternate:_____

DOB: _____ Social Security #: _____

Email: _____

How did you hear about us? _____

Insurance Information

Primary Insurance _____

ID# _____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birth date _____ Subscriber SS#_____

Secondary Insurance _____

ID# _____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birthdate _____ Subscriber SS#_____

Family Doctor _____ Phone # _____

Are you currently being treated by any other physician(s)?
☐No ☐Yes (If Yes; Please list with phone number)

_____

| List of Medications (below) | Dosage | How Often Take |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Name of Pharmacy _____Phone # _____

List ALL Allergies _____


Patient Name:_____ Date: _____

Mark any of the following conditions you or a family member has EVER experienced?

| Condition | Self | Family | Please Explain |
|---|---|---|---|
| Sinusiti | ☐ | ☐ | _____ |
| Hypothyroidism | ☐ | ☐ | _____ |
| Skin cancer | ☐ | ☐ | _____ |
| Abnormal moles | ☐ | ☐ | _____ |
| Psoriasis | ☐ | ☐ | _____ |
| Eczema | ☐ | ☐ | _____ |
| Hives | ☐ | ☐ | _____ |
| Asthma | ☐ | ☐ | _____ |
| COPD | ☐ | ☐ | _____ |
| Lung cancer | ☐ | ☐ | _____ |
| Pneumonia | ☐ | ☐ | _____ |
| Atrial fibrillation | ☐ | ☐ | _____ |
| Murmur | ☐ | ☐ | _____ |
| Angina (chest pain) | ☐ | ☐ | _____ |
| Ankle swelling | ☐ | ☐ | _____ |
| Heart attack | ☐ | ☐ | _____ |
| High blood pressure | ☐ | ☐ | _____ |
| Rheumatic/Scarlet fever | ☐ | ☐ | _____ |
| Gastric reflux (GERD) | ☐ | ☐ | _____ |
| Gastric bleeding | ☐ | ☐ | _____ |
| Colon cancer | ☐ | ☐ | _____ |
| Prostate/cancer enlargement | ☐ | ☐ | _____ |
| Testicular cancer | ☐ | ☐ | _____ |
| Pinched nerve | ☐ | ☐ | _____ |
| Spinal stenosis | ☐ | ☐ | _____ |
| Stroke/seizures/TIA | ☐ | ☐ | _____ |
| Diabetes (type) | ☐ | ☐ | _____ |
| Breast cancer | ☐ | ☐ | _____ |
| Anemia | ☐ | ☐ | _____ |

Surgeries & Dates:

_____

Are you pregnant? ☐No ☐Yes Number of Pregnancies _____Number of Births _____

Vein Institute OF THE DESERT

Patient Name: _____ Date: _____

Habits

Do you drink alcoholic beverages? ☐No ☐Yes (#/week _____) Do you now or have you ever used tobacco? ☐No ☐Yes (Packs/week _____)Quit Date, if applicable _____Do you exercise regularly? ☐No ☐Yes (#of days / week _____)

Vein History

When did you first notice your enlarged or discolored veins?_____

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg(s), (Circle) Right Leg / Left Leg / Both

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long?_____

Do you have a family history of vein problems? ☐ No ☐ Yes, What family member?

_____

Please ☐ next to the symptoms that apply to you: ☐ Aching leg(s) ☐ Appearance ☐ Burning ☐ Cramps
☐ Dull Pain ☐ Heaviness ☐ Itching ☐ Leg Ulcers
☐ Restless Legs ☐ Sharp Pain ☐ Swelling ☐ Throbbing
☐ Tiredness ☐ Other: _____

| | |
|---|---|
| Phlebitis (Clot in surface veins in legs)? | ❑ No ❑ Yes, When |
| Deep Vein Thrombosis (Clot in deep veins)? | ❑ No ❑ Yes, When |
| Pulmonary Embolus (Blood clot in lungs)? | ❑ No ❑ Yes, When |
| Bleeding from veins? | ❑ No ❑ Yes, When |
| Have you had scierotherapy before? | ❑ No ❑ Yes, When |
| Venogram (Vein X-Ray) | ❑ No ❑ Yes, When |
| Have you ever had vein surgery? | ❑ No ❑ Yes, When |
| Hemorrhoids? | ❑ No ❑ Yes, When |
| IV drug use? | ❑ No ❑ Yes, When |
| AIDS/HIV/hepatitis? | ❑ No ❑ Yes, When |
| Trauma/injury to your legs? | ❑ No ❑ Yes, When |
| Clotting disorder? | ❑ No ❑ Yes, When |

Vein Institute of the Desert

Patient Name _____Date_____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Decreased appetite | ☐ No ☐ Yes | Anxiety | ☐ No ☐ Yes | Cough | ☐ No ☐ Yes |
| Change in weight | ☐ No ☐ Yes | Confusion | ☐ No ☐ Yes | Respiratory pain | ☐ No ☐ Yes |
| High blood pressure | ☐ No ☐ Yes | Depression | ☐ No ☐ Yes | COPD | ☐ No ☐ Yes |
| High cholesterol | ☐ No ☐ Yes | Delusions | ☐ No ☐ Yes | Prod. of sputum | ☐ No ☐ Yes |
| Fatigue | ☐ No ☐ Yes | Easy bruising | ☐ No ☐ Yes | Coughing blood | ☐ No ☐ Yes |
| Fevers | ☐ No ☐ Yes | Anemia | ☐ No ☐ Yes | Apnea | ☐ No ☐ Yes |
| Cancer | ☐ No ☐ Yes | Clotting disorder | ☐ No ☐ Yes | Wheezing | ☐ No ☐ Yes |
| Decreased vision | ☐ No ☐ Yes | Bleeding disorder | ☐ No ☐ Yes | Bronchitis | ☐ No ☐ Yes |
| Double vision | ☐ No ☐ Yes | Pain in leg at rest | ☐ No ☐ Yes | Pneumonia | ☐ No ☐ |
| Temporary blindness | ☐ No ☐ Yes | Leg pain when walking | ☐ No ☐ Yes | Bone/joint deformity | ☐ No ☐ Yes |
| Blurred vision | ☐ No ☐ Yes | Slow healing leg wound | ☐ No ☐ Yes | Joint swelling | ☐ No ☐ Yes |
| Detached retina | ☐ No ☐ Yes | Sensitivity to cold | ☐ No ☐ Yes | Back pain | ☐ No ☐ Yes |
| Temporal arteritis | ☐ No ☐ Yes | Arterial disease | ☐ No ☐ Yes | Muscle aches | ☐ No ☐ Yes |
| Paralysis | ☐ No ☐ Yes | History of gangrene | ☐ No ☐ Yes | Limited motion | ☐ No ☐ Yes |
| Weakness | ☐ No ☐ Yes | Change in moles | ☐ No ☐ Yes | Knee replacement | ☐ No ☐ Yes |
| Seizure | ☐ No ☐ Yes | Itching | ☐ No ☐ Yes | Hip replacement | ☐ No ☐ Yes |
| Fainting | ☐ No ☐ Yes | Rash | ☐ No ☐ Yes | Spinal problems | ☐ No ☐ Yes |
| Headache | ☐ No ☐ Yes | Dry skin | ☐ No ☐ Yes | Thyroid disorder | ☐ No ☐ Yes |
| Migraine | ☐ No ☐ Yes | Chronic skin problems | ☐ No ☐ Yes | Diabetes w/ insulin | ☐ No ☐ Yes |
| Stroke | ☐ No ☐ Yes | Sore throat | ☐ No ☐ Yes | Diabetes -no insulin | ☐ No ☐ Yes |
| Numbness in limbs | ☐ No ☐ Yes | Sinus drainage | ☐ No ☐ Yes | Extreme appetite | ☐ No ☐ Yes |
| Slurred speech | ☐ No ☐ Yes | Hoarseness | ☐ No ☐ Yes | Extreme thirst | ☐ No ☐ Yes |
| Decreased memory | ☐ No ☐ Yes | Discharge from ears | ☐ No ☐ Yes | Lupus | ☐ No ☐ Yes |
| Ankle swelling | ☐ No ☐ Yes | Nose bleeds | ☐ No ☐ Yes | Rheumatoid arthritis | ☐ No ☐ Yes |
| Atrial fibrillation | ☐ No ☐ Yes | Hearing loss | ☐ No ☐ Yes | **FEMALE ONLY** | |
| Labored breathing | ☐ No ☐ Yes | Ringing in ears | ☐ No ☐ Yes | Irregular periods | ☐ No ☐ Yes |
| Dizziness | ☐ No ☐ Yes | Painful swallowing | ☐ No ☐ Yes | Breast problems | ☐ No ☐ Yes |
| Congenital heart dis. | ☐ No ☐ Yes | Indigestion | ☐ No ☐ Yes | Menopause | ☐ No ☐ Yes |
| Rheumatic heart dis. | ☐ No ☐ Yes | Vomiting | ☐ No ☐ Yes | Last pelvic exam | _____ mo / year |
| Murmur | ☐ No ☐ Yes | Vomiting blood | ☐ No ☐ Yes | Last period | _____ year |
| Loss of consciousness | ☐ No ☐ Yes | Gall bladder problems | ☐ No ☐ Yes | | |
| Palpitations | ☐ No ☐ Yes | Liver disease | ☐ No ☐ Yes | | |
| Chest pain | ☐ No ☐ Yes | Hemorrhoids | ☐ No ☐ Yes | | |
| Chest discomfort | ☐ No ☐ Yes | Diarrhea | ☐ No ☐ Yes | | |
| Unable to urinate | ☐ No ☐ Yes | Jaundice | ☐ No ☐ Yes | | |
| Painful urination | ☐ No ☐ Yes | Constipation | ☐ No ☐ Yes | | |
| Prostate problems | ☐ No ☐ Yes | Abdominal pain | ☐ No ☐ Yes | | |
| Kidney/bladder dis. | ☐ No ☐ Yes | Bloody stools | ☐ No ☐ Yes | | |
| Decr. urine stream | ☐ No ☐ Yes | Change in stool color | ☐ No ☐ Yes | | |
| Kidney failure | ☐ No ☐ Yes | Change in bowel habits | ☐ No ☐ Yes | | |
| Blood in urine | ☐ No ☐ Yes | | | | |
| Excessive urination | ☐ No ☐ Yes | | | | |

**OFFICE USE ONLY**