Vein Institute OF THE DESERT

Please complete the Patient Intake Forms and **fax them to 760-610-5601 or bring them with you to your first appointment.** Faxing will expedite the process of determining insurance involvement if appropriate.

PATIENT INFORMATION

Patient Name: _____ Date: _____

Mailing Address: _____

City, State, Zip: _____ Primary Phone: _____

Cell #: _____ Occupation: _____

DOB: _____ Social Security #: _____ - ____ - _____

Email: _____

HOW DID YOU HEAR ABOUT US?

☐ Desert Sun ☐ TV Commercial ☐ Ref by Physician ☐ Ref by Friend

☐ Vein Institute Website ☐ Billboard ☐ Internet Search ☐ Brochure

☐ Drive By ☐ Other: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber DOB: _____ Subscriber SSI #: _____ - _____ - _____

Family Doctor: _____ Phone #: _____

☐ No ☐ Yes: *(if YES, please list with phone #:)* _____

LIST OF MEDICATIONS

Name of Medication	*Dosage*	*How often taken?*

Name of Pharmacy: _____ Phone #: _____

List ALL Allergies: _____

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

CONDITION	SELF	FAMILY	PLEASE EXPLAIN:
Sinusitis	☐	☐	_____
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 # of Pregnancies: _____ # of Births: _____

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HABITS

Do you drink alcoholic beverages? ☐ NO ☐ YES #/week: _____

Do you now or have you ever used tobacco? ☐ NO ☐ YES # pack/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
If Yes, when and for how long?
_____

Do you have a family history of vein problems? ☐ NO ☐ YES
If Yes, what family member?
_____

Please [X] 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: _____		

Have you ever had sclerotherapy before?	☐ NO	☐ YES	If YES, when: _____
Have you ever had vein surgery?	☐ NO	☐ YES	If YES, when: _____
Phlebitis (clot in surface veins in legs)?	☐ NO	☐ YES	If YES, when: _____
Deep Vein Thrombosis (clot in deep veins)?	☐ NO	☐ YES	If YES, when: _____
Pulmonary Embolus (blood clot in lungs)?	☐ NO	☐ YES	If YES, when: _____
Hemorrhoids?	☐ NO	☐ YES	If YES, when: _____
IV drug use?	☐ NO	☐ YES	If YES, when: _____
AIDS | HIV | Hepatitis?	☐ NO	☐ YES	If YES, when: _____
Trauma | Injury to your legs?	☐ NO	☐ YES	If YES, when: _____
Clotting disorder?	☐ NO	☐ YES	If YES, when: _____

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Patient Name: _____ Date: _____

Please mark **YES** if your symptoms pertain to **TODAY'S DATE**. All others are to be marked **NO**.

Decreased appetite	☐	NO	☐	YES	Anxiety	☐	NO	☐	YES	COPD	☐	NO	☐	YES
Change in weight	☐	NO	☐	YES	Confusion	☐	NO	☐	YES	Prod of sputum	☐	NO	☐	YES
High blood pressure	☐	NO	☐	YES	Depression	☐	NO	☐	YES	Coughing blood	☐	NO	☐	YES
High cholesterol	☐	NO	☐	YES	Delusions	☐	NO	☐	YES	Apnea	☐	NO	☐	YES
Fatigue	☐	NO	☐	YES	Easy bruising	☐	NO	☐	YES	Wheezing	☐	NO	☐	YES
Fevers	☐	NO	☐	YES	Anemia	☐	NO	☐	YES	Bronchitis	☐	NO	☐	YES
Cancer	☐	NO	☐	YES	Clotting disorder	☐	NO	☐	YES	Pneumonia	☐	NO	☐	YES
Decreased vision	☐	NO	☐	YES	Bleeding disorder	☐	NO	☐	YES	Bone \ joint deformity	☐	NO	☐	YES
Double vision	☐	NO	☐	YES	Pain in leg at rest	☐	NO	☐	YES	Joint swelling	☐	NO	☐	YES
Temporary blindness	☐	NO	☐	YES	Leg pain when walking	☐	NO	☐	YES	Back pain	☐	NO	☐	YES
Blurred vision	☐	NO	☐	YES	Slow healing leg wound	☐	NO	☐	YES	Muscle aches	☐	NO	☐	YES
Detached retina	☐	NO	☐	YES	Sensitivity to cold	☐	NO	☐	YES	Limited motion	☐	NO	☐	YES
Temporal arteritis	☐	NO	☐	YES	Arterial disease	☐	NO	☐	YES	Knee replacement	☐	NO	☐	YES
Paralysis	☐	NO	☐	YES	History of gangrene	☐	NO	☐	YES	Hip replacement	☐	NO	☐	YES
Weakness	☐	NO	☐	YES	Change in moles	☐	NO	☐	YES	Spinal problems	☐	NO	☐	YES
Seizure	☐	NO	☐	YES	Itching	☐	NO	☐	YES	Thyroid disorder	☐	NO	☐	YES
Fainting	☐	NO	☐	YES	Rash	☐	NO	☐	YES	Diabetes with insulin	☐	NO	☐	YES
Headache	☐	NO	☐	YES	Dry skin	☐	NO	☐	YES	Diabetes no insulin	☐	NO	☐	YES
Migraine	☐	NO	☐	YES	Chronic skin problems	☐	NO	☐	YES	Extreme appetite	☐	NO	☐	YES
Stroke	☐	NO	☐	YES	Sore throat	☐	NO	☐	YES	Extreme thirst	☐	NO	☐	YES
Numbness in limbs	☐	NO	☐	YES	Sinus drainage	☐	NO	☐	YES	Lupus	☐	NO	☐	YES
Slurred speech	☐	NO	☐	YES	Hoarseness	☐	NO	☐	YES	Rheumatoid arthritis	☐	NO	☐	YES
Decreased memory	☐	NO	☐	YES	Discharge from ears	☐	NO	☐	YES					
Ankle swelling	☐	NO	☐	YES	Nose bleeds	☐	NO	☐	YES	FEMALE ONLY				
Atrial fibrillation	☐	NO	☐	YES	Hearing loss	☐	NO	☐	YES	Irregular periods	☐	NO	☐	YES
Labored breathing	☐	NO	☐	YES	Ringing in ears	☐	NO	☐	YES	Breast problems	☐	NO	☐	YES
Dizziness	☐	NO	☐	YES	Painful swallowing	☐	NO	☐	YES	Menopause	☐	NO	☐	YES
Congenital heart disease	☐	NO	☐	YES	Indigestion	☐	NO	☐	YES	Last pelvic exam:	Mo/year:			
Rheumatic heart disease	☐	NO	☐	YES	Vomiting	☐	NO	☐	YES	Last period:	Year:			
Murmur	☐	NO	☐	YES	Vomiting blood	☐	NO	☐	YES					
Loss of consciousness	☐	NO	☐	YES	Gall bladder problems	☐	NO	☐	YES					
Palpitations	☐	NO	☐	YES	Liver disease	☐	NO	☐	YES	OFFICE USE ONLY				
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 disorder	☐	NO	☐	YES	Bloody stools	☐	NO	☐	YES					
Decreased 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	Cough	☐	NO	☐	YES					
Excessive urination	☐	NO	☐	YES	Respiratory pain	☐	NO	☐	YES					