

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 Name:	Date:	
Mailing Address:		<del></del>
City, State, Zip:	Primary Phone:	<u>.</u>
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 ☐ Bro	chure
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 Dos	age How often	ı taken?
Name of Pharmacy:	Phone #:	
List ALL Allergies:		



Patient Name.			Date					
Mark any of the following conditions you or a family member has <b>EVER</b> 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: # of Births:								



Patient Name:			Date:					
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								
$\underline{\textbf{When}}$ did you first notice your enlarged or discolor	red veins?							
<u>Where</u> are the veins you are seeking a medical opin located?	nion for	☐ Fa	ice	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	ı:							
Aching Leg(s) Appearance	ce	Burn	ing	Cramps				
Dull Pain Heaviness		Itchir	ng $\square$	Leg Ulcers				
Restless Legs Sharp Pain	1	Swell	ling $\square$	Throbbing				
Tiredness Other:								
Have you ever had sclerotherapy before?	П по	☐ YES	If YES, when:					
Have you ever had vein surgery?	☐ NO	☐ YES	If YES, when:					
Phlebitis (clot in surface veins in legs)?	□ по	YES	If YES, when:					
Deep Vein Thrombosis (clot in deep veins)?	Пио	☐ 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:					



Please mark   YES   if your symptoms pertain to   TODAY'S   DATE   All others are to be marked   NO   PES   Change in weight   NO   YES   Confusion   NO   YES   Coughing blood   NO   YES   High blood pressure   NO   YES   Depression   NO   YES   Aprilea   NO   YES   Pally blood pressure   NO   YES   Depression   NO   YES   Aprilea   NO   YES   Pally blood pressure   NO   YES   Depression   NO   YES   Aprilea   NO   YES   Pally blood pressure   NO   YES   Easy bruising   NO   YES   Wheezing   NO   YES   Pally blood pressure   NO   YES   Easy bruising   NO   YES   Wheezing   NO   YES   Pally blood   NO   YES   Pally blood pressure   NO   YES   Pally blood   NO   YES   Pally bl	Patient Name:										Date:				
Decreased appetitie	Please mark VES if your symptoms portain to TODAY'S DATE. All others are to be marked NO														
Change in weight	Please mark $\underline{YES}$ if your symptoms pertain to $\underline{IODAY'S}$ $\underline{DAIE}$ . All others are to be marked NO.														
High blood pressure	Decreased appetite		NO		YES	Anxiety		NO	☐ YI	ES	COPD		NO		YES
High cholesterol	Change in weight		NO		YES	Confusion		NO	☐ YI	ES	Prod of sputum		NO		YES
Fatigue	High blood pressure		NO		YES	Depression		NO	☐ YI	ES	Coughing blood		NO		YES
Fevers	High cholesterol		NO		YES	Delusions		NO	☐ YI	ES	Apnea		NO		YES
Cancer	Fatigue		NO		YES	Easy bruising		NO	☐ YI	ES	Wheezing		NO		YES
Deutse   No	Fevers		NO		YES	Anemia		NO	☐ YI	ES	Bronchitis		NO		YES
Double vision	Cancer		NO		YES	Clotting disorder		NO	☐ YI	ES	Pneumonia		NO		YES
Mo	Decreased vision		NO		YES	Bleeding disorder		NO	☐ YI	ES	Bone \ joint deformity		NO		YES
Blurred vision	Double vision		NO		YES	Pain in leg at rest		NO	☐ YI	ES	Joint swelling		NO		YES
Detached retina	Temporary blindness		NO		YES	Leg pain when walking		NO	☐ YI	ES	Back pain		NO		YES
Temporal arteritis	Blurred vision		NO		YES	Slow healing leg wound		NO	☐ YI	ES	Muscle aches		NO		YES
Paralysis	Detached retina		NO		YES	Sensitivity to cold		NO	☐ YI	ES	Limited motion		NO		YES
No	Temporal arteritis		NO		YES	Arterial disease		NO	☐ YI	ES	Knee replacement		NO		YES
No	Paralysis		NO		YES	History of gangrene		NO	☐ YI	ES	Hip replacement		NO		YES
Fainting	Weakness		NO		YES	Change in moles		NO	☐ YI	ES	Spinal problems		NO		YES
Headache	Seizure		NO		YES	Itching		NO	☐ YI	ES	Thyroid disorder		NO		YES
Migraine	Fainting		NO		YES	Rash		NO	☐ YI	ES	Diabetes with insulin		NO		YES
Stroke           NO   YES         Sore throat         NO   YES         Extreme thirst         NO   YES         YES           Numbness in limbs           NO   YES         Sinus drainage           NO   YES         Lupus         NO   YES         YES           Slurred speech           NO   YES         Hoarseness           NO   YES         Rheumatoid arthritis           NO   YES         PES           Decreased memory           NO   YES         Hoarseness           NO   YES         Rheumatoid arthritis           NO   YES         Rheumatoid arthritis           NO   YES         PES           Ankle swelling           NO   YES         Hearing loss           NO   YES         Irregular periods           NO   YES         Labored breathing           NO   YES         Ringing in ears           NO   YES         Breast problems           NO   YES         PES           Dizziness           NO   YES         Ringing in ears           NO   YES         Menopause           NO   YES         NO   YES           Congenital heart disease           NO   YES         Veniting           NO   YES         Last period:         No/Wolyear:           NO   YES           Loss of consciousness           NO   YES         Gall bladder problems           NO   YES           NO   YES           NO   YES           NO   YES           NO   YES	Headache		NO		YES	Dry skin		NO	☐ YI	ES	Diabetes no insulin		NO		YES
Numbness in limbs         No         YES         Sinus drainage         No         YES         Lupus         No         YES         YES         Slurred speech         No         YES         Hoarseness         No         YES         Rheumatoid arthritis         No         YES         PES         Decreased memory         No         YES         No         YES         Rheumatoid arthritis         No         YES         No	Migraine		NO		YES	Chronic skin problems		NO	☐ YI	ES	Extreme appetite		NO		YES
Slurred speech	Stroke		NO		YES	Sore throat		NO	☐ YI	ES	Extreme thirst		NO		YES
Decreased memory         □         NO         □         YES         Discharge from ears         □         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         Ringing in ears         □         NO         □         YES         Breast problems         □         NO         □         YES           Congenital heart disease         □         NO         □         YES         Vomiting blood         □         YES         Last pelvic exam:         Molyear:         ■         NO         □         YES         Vomiting blood         □         YES         Liver disease         □         NO         □         YES         OFFICE USE ONLY         □         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■         ■	Numbness in limbs		NO		YES	Sinus drainage		NO	☐ YI	ES	Lupus		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         NO         YES           Congenital heart disease         NO         YES         Indigestion         NO         YES         Last pelvic exam:         Mo/year:         NO         YES           Rheumatic heart disease         NO         YES         Vomiting         NO         YES         Last period:         Year:         Year:           Loss of consciousness         NO         YES         Soll bladder problems         NO         YES         OFFICE USE ONLY         YES         Chest discomfort         NO         YES         Hemorrhoids         NO         YES         OFFICE USE ONLY         YES         YES         Unable to urinate         NO         YES         Abdominal pain         NO         YES	Slurred speech		NO		YES	Hoarseness		NO	☐ YI	ES	Rheumatoid arthritis		NO		YES
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         Vomiting         NO         YES         Last pelvic exam:         Mo/year:           Rheumatic heart disease         NO         YES         Vomiting         NO         YES         Last period:         Year:         Year:           Loss of consciousness         NO         YES         Gall bladder problems         NO         YES         OFFICE USE ONLY         YES           Palpitations         NO         YES         Hemorrhoids         NO         YES         OFFICE USE ONLY         YES           Chest pain         NO         YES         Jaundice         NO         YES         NO         YES           Unable to urinate         NO         YES         Abdominal pain         NO         YES	Decreased memory		NO		YES	Discharge from ears		NO	☐ YI	ES					
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:         NO         Year:         Year:         NO         Year:         Year:<	Ankle swelling		NO		YES	Nose bleeds		NO	☐ YI	ES	FEMALE ONLY				
Dizziness         NO         YES         Painful swallowing         NO         YES         Menopause         NO         YES           Congenital heart disease         NO         YES         Indigestion         NO         YES         Last pelvic exam:         Mo/year:         No         Year:	Atrial fibrillation		NO		YES	Hearing loss		NO	☐ YI	ES	Irregular periods		NO		YES
Congenital heart disease	Labored breathing		NO		YES	Ringing in ears		NO	☐ YI	ES	Breast problems		NO		YES
Rheumatic heart disease	Dizziness		NO		YES	Painful swallowing		NO	☐ YI	ES	Menopause		NO		YES
Murmur         NO         YES         Vomiting blood         NO         YES         More of Consciousness         NO         YES         Gall bladder problems         NO         YES         OFFICE USE ONLY           Palpitations         NO         YES         Liver disease         NO         YES         OFFICE USE ONLY           Chest pain         NO         YES         Hemorrhoids         NO         YES         Feature           Chest discomfort         NO         YES         Diarrhea         NO         YES         Feature           Unable to urinate         NO         YES         Jaundice         NO         YES         Feature           Painful urination         NO         YES         Constipation         NO         YES         Feature           Prostate problems         NO         YES         Abdominal pain         NO         YES         Feature	Congenital heart disease		NO		YES	Indigestion		NO	☐ YI	ES	Last pelvic exam:	Mo/y	ear:		
Loss of consciousness	Rheumatic heart disease		NO		YES	Vomiting		NO	☐ YI	ES	Last period:	Year	:		
Palpitations         □         NO         □         YES         Liver disease         □         NO         □         YES         OFFICE USE ONLY           Chest pain         □         NO         □         YES         Hemorrhoids         □         NO         □         YES         Diarrhea         □         NO         □         YES         Diarrhea         □         NO         □         YES         Diarrhea         □         NO         □         YES         Paundice         □         NO         □         YES         Prostate problems         □         NO         □         YES         Abdominal pain         □         NO         □         YES         Image: No	Murmur		NO		YES	Vomiting blood		NO	☐ YI	ES					
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	Loss of consciousness		NO		YES	Gall bladder problems		NO	☐ YI	ES					
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	Palpitations		NO		YES	Liver disease		NO	☐ YI	ES	OFFICE USE ONLY				
Unable to urinate	Chest pain		NO		YES	Hemorrhoids		NO	☐ YI	ES					
Painful urination	Chest discomfort		NO		YES	Diarrhea		NO	☐ YI	ES					
Prostate problems	Unable to urinate		NO		YES	Jaundice		NO	☐ YI	ES					
·	Painful urination		NO		YES	Constipation		NO	☐ YI	ES					
	Prostate problems		NO		YES	Abdominal pain		NO	☐ YI	ES					
	Kidney   bladder disorder					Bloody stools									
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		_				•									