OPTIMA MEDICAL CARE

Name: ____ DOB:______________________ Age: ___________

Sex: F M Height: ________ Weight: _________ SS#: ______________________

Mailing address: ____ Apt/Unit: _______

City: _____________________ State: _______ Zip: ___________

Cell: ________________________ Home: ____________________ Work: _______________________

Contact preference: Cellphone Home phone Work phone

Email address: ____________________________________

☐ I give consent to send appointment reminders

☐ I give consent to have access to Patient Portal

☐ Married ☐ Single ☐ Divorced ☐ Widow

Emergency Contact: ________________________ Relationship to you: ___________________Phone: _______________

I hearby designate the following person to access my Health information:

____ Relationship to you _______________________

Race:

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Black Hispanic or Latino

☐ Native Hawaiian /Pacific Islander ☐ White ☐ White Hispanic or Latino ☐ Other: ________________

☐ Hispanic/Latino ☐ Non Hispanic

Language: Spoken ________________ Read _________________ How did you hear about us? ______________

PHYSICIAN INFORMATION May we send a report? YES / NO

Primary Care Physician: ___________________________ Physical Therapist: _____________________________________

Cardiologist/Vascular: ____________________________ Orthopedist/Podiatrist: __________________________________

Dermatologist/Aesthetician: _________________________ Other: ____

Pharmacy _________________________ Address _______________________________ P# _________________________

INSURANCE INFORMATION

Primary: ______________________

Policy #: ______________________

Group #: _____________________

Policy holder: ________________

Relationship to policy holder:

☐Self ☐Spouse ☐Child ☐Other

Secondary: __________________

Policy #: ______________________

Group #: ____________________

Policyholder:_________________

Relationship to policy holder:

☐Self ☐Spouse ☐Child ☐Other

I HAVE RECEVIED A COPY OF:

☐ FINANCIAL AGREEMENT

☐ NOTICE OF PRIVACY PRACTICE

☐ INFORMED CONSENT

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HISTORY OF PRESENT ILLNESS

Briefly explain the reason for your visit today: ____

Do your legs or ankle currently:

□ Hurt/Ache/Throb/Burn □ Swelll □ Become tired/ heavy □ Cramping □ Restless legs

Pain scale 1-10: ______ □ Itch □ Other:________________________

Please check if you have ever had:

□ Visible veins □ Bleeding from leg veins □ Calf Pain w walks

□ Leg swelling □ Transfusion for leg bleeding □ Blood clots in legs

□ Skin discoloration below your knee □ Ankle sores/ ulcerations □ Other _______________

How do your symptoms negatively affect your daily activities? (work/daily functional living)

Example 1:____

Example 2:____

Other: ____

Are you on your feet for long periods? Y N Reason? ____

Evolution began: ____________ years/months ago

Please check any methods you have used to relieve your leg discomfort:

□ Leg Elevation □ Exercise/ Walking

□ Aspirin/ Tylenol/ Ibuprofen/ Other: ___________ Taking for how long: ______ years/months

□ Support Stockings: Knee High Thigh high Panty Hose For how long? ______ years/months

Prescribed by Physician: _______________________________ Date Prescribed: ______________________

Results from wearing compression stocking: ____

(Insurance Coverage Requirements-please note your insurance company requires you to have tried support stockings for a minimum of 3 months in order to approve treatment)

PREVIOUS VENOUS TREATMENTS

□ None prior

□ Surgery/ Stripping □ EVLT/ Laser □ Sclerotherapy/ Injections

□ Radiofrequency/ VNUS □ Laser for spider Veins □ Cosmetic Injections

□ Phlebectomy/TriVex □ Other ____________________________

Treated by? ____ When? ______________________________

Results from treatment: _________________________________

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PLEASE CHECK IF YOU HAVE EVER BEEN TREATED FOR □ None Prior

□ Allergies	□ Heart disease	□ Mitral valve prolapse
□ Arrhythmias	□ Heart murmur	□ Peripheral artery disease
□ Asthma	□ Hepatitis/ Liver disease	□ Pulmonary embolus
□ Bleeding/ blood disorder	□ HIV	□ Rheumatoid disease
□ Cancer	□ High blood pressure	□ Seizures
□ Chest pain/ tightness	□ Inflammatory Bowel	□ Stroke
□ Deep vein thrombosis/clot	□ Kidney disease	□ Trauma to the legs
□ Diabetes	□ Migraine headaches	□ Other_______________________

SYMPTOMS YOU HAVE RECENTLY EXPERIENCED (past 6 weeks): □ None Prior

□ Pregnancy	□ Fatigue/weakness	□ Joint pain
□ Ankle skin changes	□ Fever	□ Calf pain w regular walks
□ Easy bruising	□ Headaches/migraines	□ Skin rashes
□ Leg ulcers	□ Visual Disturbances	□ Numbness/tingling
□ Bleeding of a vein	□ Chest pain/tightness	□ Twitching/paralysis
□ Clotting of a vein	□ Difficulty breathing	□ Anxiety
□ Leg trauma	□ Nausea/vomiting/belly pain	□ Depression

Please list any Surgeries and the year you had them □ None

_____________________ Month/Year: _____________ _____________________ Month/Year: _____________

_____________________ Month/Year: _____________ _____________________ Month/Year: _____________

_____________________ Month/Year: _____________ _____________________ Month/Year: _____________

_____________________ Month/Year: _____________ _____________________ Month/Year: _____________

SOCIAL HISTORY

Cigarette/Tobacco: # of packs ___________ per day week month former never

Alcoholic drinks: # of glasses ___________ per day week month former never

FAMILY MEDICAL HISTORY

Is there a history in your FAMILY of spider or varicose veins? Yes / No Father/Mother ________________

Is there a history in your FAMILY of DVT or Clotting Disorder? Yes / No Father/Mother ________________

Is there a history in your FAMILY of diabetes, high blood pressure, stroke, sudden death or other major health issue?

Yes / No Father/Mother ________________

OPTIMA MEDICAL CARE

CURRENT MEDICATIONS ☐ None

Please list all medicines that you take: Prescription, Non-Prescription, Vitamins and Herbal

_________________________ for: _______________ _________________________ for: ________________

________________________ for: _______________ _________________________ for: ________________

________________________ for: _______________ _________________________ for: ________________

________________________ for: _______________ _________________________ for: ________________

________________________ for:________________ _________________________ for: ________________

ALLERGIES

☐ None ☐Latex ☐ Skin Tape

☐ Drug Allergies: _______________________________

FOR FEMALES ONLY:

☐ Currently Pregnant ☐ Trying to become pregnant ☐ Breast Feeding

☐ Number of pregnancies: ________ ☐ Number of stillbirths/miscarriages: ______

☐ Date of Last Menstrual period: _______________

Are you currently experiencing any of the following:

☐ Pelvic Pain or heaviness ☐ Veins on upper thighs, vulva or labia

The above information has been given to the best of my knowledge:

Patient Signature: ____ Date: _________________________