# OPTIMA VEIN CARE

Name: _____ DOB:_____ Age: ____YO Sex: F M

Height: _____ Weight: _____lbs SS#: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widow

Mailing Address: _____ Apt/Unit: _____ City: _____ State: _____ Zip: _____

**Check Contact preference:** ☐ Cell _____ ☐ Home _____ ☐ Work _____

Employer _____ Email Address: _____

Job Title _____

By initialing, I give consent for the following:
____ Contact me through email
____ Establish a patient portal account

**Emergency Contact**

Name _____ Relationship to you _____ Phone: _____

☐ **I DO NOT GIVE** anyone consent to coordinate my appointments and to have access to my health information.

☐ **I GIVE** the following person consent to coordinate my appointments and have access to my health information.

☐ **Check, if the same as emergency contact**

Name _____ Relationship to you _____ Phone: _____

**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 progress report? YES / NO

Primary Care Physician: _____ Physical Therapist: _____

Cardiologist/Vascular: _____ Orthopedist/Podiatrist: _____

Dermatologist/Aesthetician: _____ Other: _____

Pharmacy _____ Address _____ P# _____

**INSURANCE INFORMATION**

Primary: _____ Secondary: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Policy holder: _____ Policyholder:_____

Relationship to policy holder:
☐Self ☐Spouse ☐Child ☐Other

Relationship to policy holder:
☐Self ☐Spouse ☐Child ☐Other

**By initialing, I have read and was offered a copy of:**

**_____ FINANCIAL AGREEMENT Initial**
**_____ NOTICE OF PRIVACY PRACTICE Initial**

# OPTIMA VEIN CARE

**Briefly explain the reason for your visit today:** _____

**Do your legs/ ankle currently:**

□ Hurt/Ache/Throb/Burn □ Swelling □ Become tired/ heavy □ Cramp □ Restless legs
Pain scale 1-10: _____ □ Itch □ Other:_____

**Please check if you have ever had:**

□ Visible veins □ Bleeding from leg veins □ Calf Pain wile walking/standing

□ 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** □ No history of vein treatments

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

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

□ Phlebectomy/TriVex □ Other _____

Treated by? _____ When? _____

Results from treatment: _____

# OPTIMA VEIN CARE

**REVIEW OF SYSTEM:**

**Const. (Health in General)** ❑ No Problems
Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer
Other: _____

**Ears, Nose, Mouth & Throat** ❑ No Problems
Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other: _____

**C-V (Heart & Blood Vessels)** ❑ No Problems
Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: _____

**Resp. (Lungs & Breathing)** ❑ No Problems
Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: _____

**GI (Stomach & Intestines)** ❑ No Problems
Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other: _____

**GU (Kidney & Bladder)** ❑ No Problems
Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other: _____

**MS (Muscles, Bones, Joints)** ❑ No Problems
Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: _____

**Integ. (Skin, Hair & Breast)** ❑ No Problems
Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

**Neurologic (Brain & Nerves)** ❑ No Problems
Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: _____

**Psychiatric (Mood & Thinking)** ❑ No Problems
Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

**Endocrinologic (Glands)** ❑ No Problems
Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

**Hematologic (Blood/Lymph)** ❑ No Problems
Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: _____

**Allergic/Immunologic** ❑ No Problems
Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.
Other:_____

**PAST MEDICAL HISTORY:** □ No history of any medical problems

| | | |
|---|---|---|
| □ Seasonal/Environmental allergies | □ DVT | □ High Cholesterol |
| □ Arthritis | □ Angina | □ Hepatitis |
| □ Varicose Veins | □ Heart Attack | □ HIV |
| □ Peripheral arterial disease | □ Congestive heart failure | □ Migraine |
| □ Clotting disorder | □ Asthma | □ MRSA |
| □ Cerebrovascular accident | □ Pulmonary embolism | □ GERD |
| □ Obesity | □ Diabetes | □ Neuropathy |
| □ Seizures | □ Renal Disease | □ COPD |
| □ Hypertension | □ Thyroid | □ IBS |

Other: _____

# OPTIMA VEIN CARE

**Please list any Surgeries and the year you had them** □ No previous surgeries

| | | |
|---|---|---|
| □ CABG | □ Appendectomy | □ Hysterectomy |
| □ Knee Replacement | □ Cholecystectomy | □ Tonsillectomy |
| □ Hip Replacement | □ Bunionectomy | □ TSA |

Other: _____

**CURRENT MEDICATIONS** □ None

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

_____ for: _____ _____ for: _____

_____ for: _____ _____ for: _____

_____ for: _____ _____ for: _____

_____ for: _____ _____ for: _____

**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 _____

Any family history of diabetes, high blood pressure, stroke, sudden death or other major health issue?

Yes / No Father/Mother _____

**ALLERGIES**

□ None □Latex □ Skin Tape □ Drug Allergies:_____

**FOR FEMALES ONLY:**

□ Currently Pregnant □ Trying to become pregnant □ Breast Feeding Last Menstrual _____

#of pregnancies: _____ How many children:_____ # of stillbirths/miscarriages: _____

**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: _____