

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 _____

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: _____ Relationship to policy holder: _____

Self Spouse Child Other 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 while 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

Arthritis

Varicose Veins

Peripheral arterial disease

Clotting disorder

Cerebrovascular accident

Obesity

Seizures

Hypertension

Other: _____

DVT

Angina

Heart Attack

Congestive heart failure

Asthma

Pulmonary embolism

Diabetes

Renal Disease

Thyroid

High Cholesterol

Hepatitis

HIV

Migraine

MRSA

GERD

Neuropathy

COPD

IBS

OPTIMA VEIN CARE

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

- | | | |
|---|--|--|
| <input type="checkbox"/> CABG | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Bunionectomy | <input type="checkbox"/> 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: _____