



**VeinCare**

*Board Certified Vascular Surgeons*

Dear Patient,

Thank you for your interest in VeinCare. Our goal is to provide you with high quality medical care with a personal touch. We will provide you with the information you need to make sound decisions regarding your health care.

Enclosed you will find a *new patient information and consent form* and a *medical history form*. Please fill these out and bring them with you to your first office visit.

If you have any questions or concern, please give our office a call.

Sincerely,

The Staff at St. Luke's VeinCare



VeinCare

PATIENT INFORMATION AND CONSENT

Date Doctor Account #

Last Name

Sex (M)ale (F)emale

First Name

Marital Status: Single Married Divorced

Address

Separated Widow Minor

City State Zip

Employer

Home Phone ( )

Family Physician

Work Phone ( )

Referring Physician

Cell Phone ( )

Other Physician to Contact

E-mail

Emergency Contact

Date of Birth

Relationship Phone

Social Security #

If married, Spouse's Name

Age

Spouse's DOB SS#

BILLING INFORMATION

Do you have medical insurance? Yes No

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Name

Name

Address

Address

ID #

ID #

Group #

Group #

Subscriber

Subscriber

Birth Date

Birth Date

Social Security #

Social Security #

Responsible Party

Phone

As patient or legal guardian of patient, I agree to be fully responsible for all charges for services rendered. I authorize my doctor or his agent to submit claims to Medicare or my insurance carriers for charges incurred. I authorize my Medicare or insurance benefits to be paid directly to the doctor. I understand that there is a possibility of non-coverage by my insurance companies or Medicare. If they determine that any service is deemed "medically unnecessary" I agree to assume responsibility for denied payment. I further authorize this office to obtain and release my medical records to and from other physicians. Medical facilities, insurance companies and Medicare to facilitate my health care and appropriate payments.

Signature

Date Signed

**MEDICAL HISTORY**

**Do you now or have you ever had any of the following (circle):**

- |                     |                        |                |
|---------------------|------------------------|----------------|
| Heart disease       | Bleeding disorders     | Stomach ulcers |
| High blood pressure | History of blood clots | Lupus          |
| Diabetes            | Asthma                 | Arthritis      |

**Do you have any medical conditions not listed above? (Please explain)**

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**SURGICAL HISTORY**

Operation	Year	Operation	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY**

**Do any members of your immediate family have, now or in the past, any of the following conditions?**

	Relationship
High blood pressure	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
Varicose Veins	_____
Blood clots in legs or lungs	_____
History of anesthetic complications	_____

**PERSONAL HABITS**

Have you ever smoked?	Yes	No	Do you regularly drink alcohol?	Yes	No
# of years smoked?	_____	_____	Beer/Wine:	_____	drinks per week
# of packs per day	_____	_____	Liquor:	_____	drinks per week
# of years since you quit?	_____	_____			

Occupation: \_\_\_\_\_

**MEDICATIONS**

*List all medications you currently take*

Brand name	Dosage & Frequency	Brand name	Dosage & Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Do you have any allergies to medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list below**

<u>Medication</u>	<u>Explain reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

**SYSTEMS REVIEW**

Normal Weight \_\_\_\_\_ lbs. Any recent change in weight? Yes No

*Please circle any signs or symptoms that apply to you*

Respiratory: Neurologic: Cardiovascular:
Shortness of breath Difficulty with coordination Rapid heart rate or palpitations
Chronic cough Numbness or loss of sensation Chest pain with activity

Skin: Women Only:
Non-healing sores How many times have you been pregnant?
Easy bruisability How many children?
History of skin cancer Are you taking birth control pills? Yes No
Could you be pregnant now? Yes No

**LEG VEIN HISTORY**

Do you or have you ever worn compression stockings? Yes No Currently using? Yes No
If yes, what compression grade of stockings have you tried? 10-15 20-30 30-40 Unknown
Approx. Date Started: Do/did they help you? Yes No

Do you experience any of the following symptoms in your legs (please circle?)

Aching/Pain Yes No Swollen Ankles Yes No
Heaviness Yes No Leg Cramps Yes No
Tiredness/Fatigue Yes No Cramps w/ walking Yes No
Itching/Burning Yes No Restless Leg Yes No
Pain/Stiffness in joints Yes No Throbbing Yes No

Are your symptoms worse at the end of the day? Yes No
Are there any other leg symptoms? Yes No If yes, please explain:

How often, if at all, do you elevate your legs for symptom relief?

How often, if at all, do you take ibuprofen, Advil or Motrin for symptom relief?

Are the problems that you are having in your legs interfering with your daily living? Yes No

If yes, please give examples:

Do you feel safe at home? Yes No

What is your preference for learning? (circle one) Verbal Visual

What is your language preference? (circle one) English Spanish Other: