DALLAS VEIN INSTITUTE

PATIENT INFORMATION

Name (First) _____(MI) _____ (Last)_____

Address_____ City_____State _____Zip Code_____

Home Phone_____Cell Phone_____ Email_____

DOB___/ ____/ ___Social Security_____ Sex Female ☐ Male ☐

Marital Status ☐ S ☐M ☐D ☐ W Occupation_____ Employer _____

Work Phone _____City _____ State ____

Insurance Information: Policy Holder: ☐ Patient ☐ Spouse

Primary _____ Member ID # _____ Group # _____

Secondary_____ Member ID # _____ Group # _____

Policy Holder Name_____DOB ___ / ____ / ____

How did you find out about us?

☐ Referral from Physician_____ ☐ Friend/Family Member_____

☐ Internet and website _____ ☐ Other_____

Physician That Referred You:

Name of Provider_____Specialty_____Phone _____

Address_____City _____State _____ Zip_____

Primary Care Physician (if other than referring physician)

Name_____Specialty_____Phone_____

Address_____City_____State _____ Zip_____

Any other Physician you would like us to send your visit notes to?

Name_____Phone_____

Address_____City_____State _____ Zip _____

Race	Ethnicity	Preferred Primary Language
☐American Indian or Alaska native ☐ Asian ☐ Black or African American ☐Native Hawaiian or Pacific Islander ☐ White ☐ Decline to state	☐Hispanic ☐ Not Hispanic ☐ Decline to State	☐ English ☐ Spanish ☐ Other: _____

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Authorization for Communication of Protected Health Information

Circle your preferences

1. **How may we contact you?**
   Cell Phone Home Phone Work Phone Email Text

2. **Emergency Contact: _____Phone #_____**

   Relationship to you: _____

3. **<u>Appointment Reminders:</u>** An automated text will be sent out 3 days in advance to remind you of upcoming appointment. An automated phone call will also be sent out 2 days in advance.
   Please confirm your appointment 48 hours in advance.

   Auto Appointment Reminder <u>Phone Calls</u>:

   Cell Phone Home Phone Work Phone

   Auto Appointment Reminder <u>Text</u> to Cell Phone:

   Yes No

4. **Other person(s) authorized to receive messages, information and discuss medical treatment on my behalf:**

   A) Name _____ @ _____

   B) Name _____ @ _____

It is frequently necessary for personnel at this practice to communicate information about appointments, instructions, test results, treatment, payment and other items of protected health information with, or ask for feedback from, our patients. It is often not possible to personally speak with the patient to communicate this information. Please provide us instructions regarding your communication preferences, including what you would like us to do if we are not able to reach you (the patient) directly.

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This authorization does not expire unless otherwise revoked in writing.

Signature of Patient or Patient/Guardian _____ Date: _____

Patient Name:_____ **DOB:** _____

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Symptoms: (please check if yes)	**R**	**L**
Aching / Pain in Legs	☐	☐
Heaviness	☐	☐
Tiredness / Fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg Cramping	☐	☐
Leg Restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your Symptoms worse with or after Activity? ☐
Do your Symptoms keep you from doing anything? ☐

Check If you've had any of the following:

Heart Disease	☐
Peripheral Arterial Disease	☐
HIV	☐
Hepatitis	☐
Diabetes	☐
Cancer	☐
Leg Trauma / Surgery	☐
Asthma / COPD	☐

Major Surgery / Hospitalizations:

_____

_____

_____

Do you have an Advanced Directive? ☐Yes ☐No

Conservative Measures used Currently or Previously: *Check all that apply*

☐ weight Loss ☐ leg elevation ☐ Job Change ☐ Exercise ☐ **Pain Medications** Which ones? _____

☐ **Compression Stockings**
if yes, how long have you worn compression stockings for? Start date: _____ to End date: _____.

Please list your **Weight**: _____ lbs **Height** :____ ft ____ in

Restless Leg Syndrome: YES ☐ NO ☐

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply*

☐ Previously diagnosed with PAD ☐ Have/had cramping leg pain that worsens with walking & forces me to stop walking

☐ Feet/toes become pale and painful with exercise or when elevating them ☐ Have/had ulcers on feet or toes

Please Check below if you have had any of the following:

☐ Prior evaluation for your veins: _____ (yr)
☐ previous vein Surgery or Laser treatments:_____ (yr) ____R_____L
☐ Previous vein Injections:_____(yr) _____R_____L
☐ Bleeding from a vein: _____(yr)____R_____L
☐ A leg Ulceration: _____(yr)_____R_____L
☐ Superficial Thrombophlebitis or Inflammation of a vein:_____(yr)_____L_____R_____(Location)
☐ Any Type of Blood Clot_____(yr)_____R_____L_____(diagnosis)
☐ Any Type of Clotting Disorder: _____(yr)_____(diagnosis)
☐ Migraines with aura
☐ Diagnosed with PFO (Patent Foramen Ovale)

☐ A family history of vein disease
☐ A Family history leg Ulcerations
☐ A Family history of Blood Clots
☐ A Family History of Clotting Disorder

Women Only:

Are you pregnant of considering a pregnancy in the future? ☐
Are you Breastfeeding? ☐
Are your legs more painful associated with menstruation? ☐
Have you Been diagnosed with Pelvic congestion Syndrome and/or had bulging veins during pregnancy? ☐
☐ Number of pregnancies:____Deliveries:_____Miscarriages:_____ Children's Age:_____

Patient Name:_____ DOB: _____

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Annual Influenza Immunization: Did you receive a flu shot during the "Flu Season"(August -March)?

Date of last flu shot___/____ ☐ No Refused ☐Decline for medical reason - ☐ Allergy ☐Other Medical Reason

Social History

Tobacco Use History ☐ Never smoked ☐Former smoker but quit on_____ (approx. date)
☐ Current smoker – Started_____ (approx. date) amount of Cigarettes:_____ per day
☐ use of tobacco in other forms- _____ Amount:_____ Per day

Alcohol use History: Did you have a drink Containing alcohol in the past year? □ NO □ YES
If Yes: How Often? □ monthly or less?_____ Drinks per month____ Drinks Per week_____ Drinks per day
How Often >6 drinks on one occasion in the past year? ☐Never ☐ Less than monthly ☐Weekly ☐Daily

Allergies and your Allergic Response: Or ☐ No Known Allergies

_____☐Rash □Nausea/Vomiting □Diarrhea □ Shortness of breath □ Anaphylaxis □Other:_____
_____☐Rash □Nausea/Vomiting □Diarrhea □ Shortness of breath □ Anaphylaxis □Other:_____
_____☐Rash □Nausea/Vomiting □Diarrhea □ Shortness of breath □ Anaphylaxis □Other:_____

Current Medications: Include Prescription drugs, Over the counter drugs, vitamins, minerals, herbals, dietary (nutritional) Supplements
□ **NONE**

#	Medication Name	Dose	Frequency	Route
1				□oral □
2				□oral □
3				□oral □
4				□oral □
5				□oral □
6				□oral □
7				□oral □
8				□oral □

Patient Signature:_____ Date:_____

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Travel Health Alert Questionnaire

Patient Name: _____ **DOB:** _____ **Date:** _____

1. **Have you done any foreign travel in the past 3 months?** □ **Yes** □ **No**

2. **Have you been practicing social distancing since March 24th, 2020?** □ **Yes** □ **No**

3. **Have you been in contact with anyone with COVID-19 or anyone who may have had it?**

   □ Yes □ No

4. **Have you had any of the following symptoms below since returning from your travels?**
   If you answered no to Question 1, you can skip this question

   ☐ Cough □ Fever □ Sneezing □ Chest Pain

   □ Runny Nose □ Headaches □ Sore Throat □ Difficulty Breathing

5. **If question #2 was answered, have you seen a healthcare professional or taken any post travel health precautions?**

   □ Yes □ No

   If yes, please explain:

   _____

   _____

Patient Signature: _____ **Date:** _____