Sky Vein & Aesthetics

Varicose & Spider Vein

Danny L. Harrison, MD, FACS
1711 Destiny Lane, Suite 120, Bowling Green, KY 42104
(270) 846-1500

Patient Name: _____ _____ ___ Date of Birth: _____
Last First MI mm/dd/yyyy

Please take your time and fill out this questionairre so that we may provide you with a personal and customized treatment plan. Thank you.

Mark ***X*** if **you have** or **TRUE**

☐ Varicose Veins
☐ Spider Veins
Do you have any leg symptoms?
Pain in legs
☐ Right ☐ Left ☐ Both
Swelling foot or ankle
☐ Right ☐ Left ☐ Both
Brown discoloration at the ankle
☐ Right ☐ Left ☐ Both
Skin ulceration
☐ Right ☐ Left ☐ Both
Superficial Thrombophlebitis
☐ Right ☐ Left ☐ Both
Bleeding from Varicose Veins
☐ Right ☐ Left ☐ Both
Varicose Vein Procedures
☐ Right ☐ Left ☐ Both
_____
_____
Varicose Vein Injections
☐ Right ☐ Left ☐ Both
Spider Vein Injections
☐ Right ☐ Left ☐ Both
Major injury to your legs?
☐ Right ☐ Left ☐ Both
_____
_____
☐ Other leg surgery
☐ Right ☐ Left ☐ Both
_____
_____
DVT (Deep Vein Thrombosis)
☐ Right ☐ Left ☐ Both
☐ PE (Pulmonary Embolus)

☐ Have been wearing compression hose
For how long?
_____
☐ Your occupation requires prolonged standing
_____
☐ Leg pain keeps you from walking.
☐ Leg pain keeps you up at night.
☐ You elevate your legs day or evening
☐ You occasionally take pain medications for leg pain.
☐ Cannot take Aleve, Advil, etc.
☐ Arthritis medications upset your stomach
☐ You have heartburn
☐ You have had stomach ulcers.

Ht: _____

Weight: _____

_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS or Problem Treated

☐ Aspirin
☐ Blood Thinner
☐ Plavix
☐ Insulin
☐ Diabetic Pills
☐ High Blood Pressure
☐ Water Pill
☐ High Cholesterol
☐ Anxiety
☐ Depression
☐ Thyroid Disease
☐ Asthma Inhaler
☐ Asthma
☐ Arthritis
☐ Birth Control
☐ Hormone Replacement
☐ Testosterone
☐ Steroids ie. Prednisone
☐ Anabolic Steroids
☐ Antibiotic for Acne
☐ Antibiotic for Skin Infection
☐ Antibiotic Other
☐ Narcotic Pain Medications
☐ Ultram
☐ Cancer Treatment
☐ Minoxidel
☐ Immunosuppressants

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MEDICAL CONDITIONS

☐ Asthma
☐ Diabetes
☐ Low Thyroid
☐ Hyperthyroid
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Migraines
☐ Bell's Palsy
☐ Epilepsy
☐ ALS
☐ Myasthenia Gravis
☐ Hepatitis
☐ Heart Disease
☐ COPD
☐ Multiple Sclerosis
☐ Melanoma
☐ Other Skin Cancer
☐ Other Cancer
☐ Peripheral Vascular Dis.
☐ Stroke, TIA
☐ Congenital Defect
☐ Serious Infection, MRSA
☐ HIV
☐ Pacemaker
☐ TB
☐ Poor Hearing
☐ Wear glasses, contacts
☐ Glaucoma

SUPPLEMENTS

☐ Vitamin A
☐ Vitamin C
☐ Fish Oil, Omega III
☐ Vitamin E
☐ Ginko Biloba
☐ Garlic
☐ Ginseng
☐ Dong Quai
☐ Vit B6 (Pyridoxine)
☐ St Johns Wort
☐ Feverfew

ALLERGIES

☐ Latex
☐ Lidocaine
☐ Penicillin
☐ Kefle
☐ Sulfa
☐ Aspirin
☐ Iodine
☐ Anaphylaxis
☐ Dermabond
☐ Cosmetic Glue, ie Eyelashes or Nails
☐ Other
_____
_____
_____

Mark ***X*** if **you have** or **TRUE**

☐ Bruises easily
☐ Bleeding disorder
☐ Current Smoker
☐ Former Smoker:
Quit _____
☐ Pregnant
☐ Breast Feeding
_____
_____
_____
_____
_____
_____
_____
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_____
_____

_____ ☐ Reviewed _____
Patient Signature Date Danny L Harrison, MD Date

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Patient Name: _____ _____ ___ Date of Birth: _____
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_____ _____
Home Address City, State, and Zip Code

_____ _____
Cell Phone Email Address

☐ YES ☐ NO May we contact you by text message regarding appointments, etc.

☐ YES ☐ NO May we contact you by email message regarding appointments, etc.

Sex: ☐ Male ☐ Female

Pharmacy: _____

Street: _____City: _____

Employer: _____ Occupation: _____☐ Retired

How did you hear about us?
☐ Facebook ☐ Google ☐ VIP BG
☐ Cable ☐ MD ☐ Instagram
☐ Yelp ☐ Radio ☐ You Tube
☐ Daily News ☐ SoKy Happenings
☐ Friend: _____

Who may we contact in case of emergency? _____ _____
Name Phone

Who is your primary physician? _____
Name

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Initial Here: _____ I hereby consent to **Danny L Harrison, MD** (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals. I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Varicose Vein Patients Only:

MEDICARE & INSURANCE ASSIGNMENT OF BENEFITS SIGNATURE ON FILE

Initial Here: _____ I request that payment of authorized Medicare OR Insurance benefits be made on my behalf to Dr Harrison for any services furnished me. Dr Harrison agrees to accept the charge determination of the Medicare carrier or Insurance Company as the full charge. The patient is responsible for the deductible, coinsurance, and non-covered services at the determination of the Medicare carrier or Insurance Company.

_____
Patient Signature Date