Patient Registration Form

VEIN CLINICS of LAKE COUNTY

Date: _____ / _____ / _____ Name: _____
Last First M.I.

Home Address: _____
City State Zip Code

Home Phone #: _____ Work #: _____ Cell #: _____

Please circle the number you prefer: Home--Work--Cell

Email for online portal access: _____

DOB: _____ / _____ / _____ SS#: _____ Age: _____

Sex: Male -- Female Marital Status (please circle): Single -- Married -- Other

Employer: _____ Occupation: _____

Pharmacy:_____ City:_____

Meaningful Use Data (Check one in each category):
Ethnicity: O Declined to Specify O Hispanic or Latino O Not-Hispanic or Latino
Race: O Caucasian O Black or African American O Hispanic or Latino O Not Hispanic or Latino
O Other Race O Declined to Specify

Preferred Language: O English O Spanish O Other: _____

Primary Insurance (please present primary insurance card at time of check-in):
Insurance Provider: _____
Secondary Insurance (please present any secondary insurance card(s)):
Insurance Provider: _____

Contacts**:**
Primary Care Physician: _____ Referring Physician: _____

Emergency Contact: _____ Relationship: _____
Home Phone #: _____ Cell #: _____

How did you hear about VCLC? (Please Circle): Internet--Website--Publication--Physician--Friend

Patient Signature: _____

Printed Name: _____ Date Signed: _____ / _____ / _____

Are you requesting a vein evaluation for medical reasons? Yes No

Patient Registration Form

VEIN CLINICS of LAKE COUNTY

What is your chief complaint or medical reason for having a vein consultation? _____

Indicate which of the following signs or symptoms you have experienced (circle all that apply):

Symptom	Left Leg	Right Leg	Symptom	Left Leg	Right Leg
Buring	L	R	Swelling	L	R
Itching	L	R	Pulmonary Embolism	L	R
Tingling	L	R	Prior Leg Ulcer	L	R
Heaviness	L	R	Worsening Leg Veins	L	R
Fatigue	L	R	Bulging Leg Veins	L	R
Pain	L	R	Prior Phlebitis (tenderness)	L	R
Discomfort	L	R	Thrombophilia (clotting)	L	R
Cramping	L	R	Ruptured/Bleeding Veins	L	R
Blood Clots	L	R	Deep Vein Thrombosis (DVT)	L	R
Ankle Swelling	L	R	Restlessness in Leg(s)	L	R

Do you have a family history of vein disease? Yes (If yes, who _____) No
Do you have a family history of blood clots? Yes (If yes, who _____) No

Have you ever smoked tobacco? Yes No Have you ever had a substance abuse problem? Yes No
Do you consume alcohol? Yes No If so, how much_____

Are you currently working? Yes No What is your occupation? _____

Are you required to sit/stand for long periods? Yes No Do you walk during your job? Yes No

When did you first become aware that you have a vein problem? _____

Have you ever (now or in the past) worn compression socks/stockings? Yes No

What relieves your symptoms:_____ Don't Know

What makes you symptoms worse:_____ Don't Know

Are you physically active? Yes No Please describe activity_____

Have you had prior vein treatments? Yes No

Indicate which prior vein treatments you have had: (place R and/or L in space to indicate leg for all that apply)

____ No prior vein treatments _____ sclerotherapy injections _____ surgical vein stripping
____ phlebectomy _____endovenous laser ablation _____ surface laser/light

List your current medications and dosages:_____

_____

Patient Registration Form

VEIN CLINICS of LAKE COUNTY

Do you have any medication allergies? Yes No If yes, please list:_____

Do you have a latex allergy? Yes No

List prior surgeries:_____

_____

Indicate which of the following conditions below you have had (check all that apply): ____ None

____ blood clotting disorder	____ anemia or bleeding disorder	____ heart defect or PFO
____ migraine headaches	____ high blood pressure	____ heart murmur
____ asthma or lung disease	____ stroke or CVA	____ diabetes
____ coronary artery disease	____ peripheral arterial disease	____ renal/kidney disease
____ hepatitis or liver disease	____ joint replacement surgery	____ cancer/malignancy
____ HIV/AIDS	____ high cholesterol	____ apnea
____ heartburn / GERD	____ anxiety	____ depression
____ skin conditions	____ atrial fibrillation	____ COPD
____ back problems	____ thyroid disorder	____ other: _____

For Women Only

Number of Pregnancies:_____ Number of Children: _____ Number of miscarriages: _____

Are you planning to get pregnant? Yes No
