BLOOMFIELD
VEIN & VASCULAR, PLLC

TODAY'S DATE_____

Last name:_____First name_____M.I. _____

DOB _____Sex (circle) F M SS# _____

Street address _____

City_____ Zip Code _____ Cell # _____

Emergency Contact Name _____ Cell # _____

Relationship _____

Do we have your permission to share your medical information with this contact? (please circle) YES NO

Is there someone else that we can share information with? If so, name _____

Pharmacy Name _____ City_____ Phone # _____

Do you give us permission to obtain your medication list from your pharmacy? (please circle) YES NO

Referring physician _____ City _____ Phone # _____

Primary Care doctor (**if different from referring doctor**) _____Phone # _____

If you were not referred by a physician, how did you find out about us? (please circle and/or fill in information)

Website Internet Search Friend (name, please) _____

Print Ad [ ] Hour [ ] Jewish News [ ] Seen [ ] The Eagle

Main Reason for your visit today _____

Please circle which lower extremity bothers you most RIGHT LEFT BOTH

Do your **thighs** or **lower legs** bother you when you walk? YES NO

If yes, how far can you walk before you experience symptoms: ___ blocks ___ mile(s)

Lower Extremity (**thighs or lower legs**) symptoms (**please circle all that apply**):

Achiness Heaviness Itching Restless Legs Swelling Throbbing

Have you noticed any of the following on your **lower legs/ankles or feet?** (circle all that apply)

Color changes to your skin A sore or wound Pain in your foot at night

Have you experienced, or do you currently experience any of the following? (circle all that apply)

Pelvic fullness Pelvic pain Heavy periods Varicose veins in unusual places N/A

Have you ever been diagnosed with **Endometriosis?** (circle) YES NO N/A

If yes, have you had laparoscopy YES NO

Have you been treated with medication YES NO

Do you wear compression stockings? (**please circle**) YES NO Tried, but didn't tolerate

Your initials _____

Medical History: (check all that apply)

[ ] Asthma
[ ] Atrial fibrillation
[ ] Back Problems / Lumbar disc disease
[ ] COPD / emphysema
[ ] **Cancer**
Type _____
[ ] Diabetes
[ ] **DVT (Blood Clot)**
LEFT RIGHT BOTH
[ ] Endometriosis
[ ] Heart Disease (CAD) / Heart Attack
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Kidney Disease (abnormal function)
[ ] Kidney Failure (dialysis)
[ ] Migraines
[ ] Patent Foramen Ovale (PFO)
[ ] **Peripheral Artery Disease (PAD)**
[ ] Positive Clotting Factor
Type _____
[ ] Pulmonary Embolism (PE)
[ ] Sciatica
LEFT RIGHT BOTH
[ ] Sleep Apnea
[ ] Stroke
[ ] SVT- (**Superficial Blood Clot**)
LEFT RIGHT BOTH
[ ] Thyroid disease
[ ] TIA
[ ] Other: _____

Surgical History: (check all that apply)

[ ] Ablation procedure (heart)
[ ] Appendix
[ ] **Any surgery on an arterial blood vessel**
Type _____
[ ] Bowel surgery
Type _____
[ ] CABG (Open heart surgery)
Year _____
[ ] C-section
[ ] Cholecystectomy (Gallbladder)
[ ] Heart Stents
Year _____
[ ] **Hip Surgery** (Replacement) -please circle
LEFT RIGHT BOTH
[ ] Hysterectomy
[ ] **Knee surgery** (Replacement) -please circle
LEFT RIGHT BOTH
[ ] Laparoscopy **Year** _____
[ ] **Lumbar surgery**
Level _____
[ ] Tubal Ligation
[ ] **Varicose Vein Surgery**
[ ] Ablation
RIGHT LEFT BOTH
[ ] Phlebectomy (vein removal)
RIGHT LEFT BOTH
[ ] Sclerotherapy
RIGHT LEFT BOTH
[ ] Stripping (**incision by your groin**)
RIGHT LEFT BOTH

MEDICATION

Are you taking any of the following medications? (check all that apply)

[ ] Aspirin [ ] Coumadin/Warfarin [ ] Plavix [ ] Eliquis [ ] Pradaxa [ ] Xarelto

List any other medications	Dose	How often?
_____	_____	[ ] once daily [ ] twice daily [ ] three times daily
_____	_____	[ ] once daily [ ] twice daily [ ] three times daily
_____	_____	[ ] once daily [ ] twice daily [ ] three times daily
_____	_____	[ ] once daily [ ] twice daily [ ] three times daily
_____	_____	[ ] once daily [ ] twice daily [ ] three times daily

If you take more than 5 medications, we strongly recommend that you provide us with a list

Have you provided us with your pharmacy information? (page 1)

Your initials _____

ALLERGIES

Are you allergic to any **medications**? [ ] YES (**list below**) [ ] NO

LIST _____

Reaction _____

Are you allergic to **LATEX**? [ ] YES [ ] NO

Are you allergic to **IV dye, Iodine, Shellfish**? [ ] YES [ ] NO

FAMILY HISTORY

Cancer [ ] Mother [ ] Father [ ] Sibling

Type _____

DVT (blood clots) [ ] Mother [ ] Father [ ] Sibling

Heart disease / heart attacks [ ] Mother [ ] Father [ ] Sibling

Varicose veins (whether treated or not) [ ] Mother [ ] Father [ ] Sibling

SOCIAL HISTORY

Do you smoke? [ ] YES [ ] NO [ ] QUIT?

If you do, how many packs/day _____ and for how many years? _____

Do you drink **daily**? [ ] YES [ ] NO [ ] QUIT?

History of drug/substance abuse? [ ] YES [ ] NO [ ] QUIT?

REVIEW OF SYSTEMS (please circle all that apply)

Constitutional	Weight loss	Fever	Fatigue	Weakness	Malaise
Eyes	Changes in vision	Floaters	Cataracts		
Ear, Nose & Throat	Nosebleeds	Gum Disease	Hoarseness	Difficulty Swallowing	
Cardiac	Chest pain	Heart murmur	Heart Failure	Valve disease	
Respiratory	Shortness of breath	Bronchitis	Pneumonia	Cough	CPAP use
GI	Stomach ulcers	GERD/Heartburn	Hepatitis	IBS	
Musculoskeletal	Back pain	Arthritis	Gout	Neck Pain	Fibromyalgia
Neurological	Dizziness	Headaches	Seizures	Numbness in feet	Fainting
Psychiatric	Anxiety	Depression	Sleep disturbances		
Hematology	Abnormal bleeding	Easy bruising			
Urological	Frequent UTIs	Kidney stones			