Please print legibly. We will scan your insurance card(s) and a photo ID upon check-in.

Date: _____

Physician: □ Carter □ Deiparine □ Kujath □ Stark □ Wagner □ Waldschmidt □ Wilson

PATIENT INFORMATION	**SPOUSE** (if applicable)
Last Name: First: MI:	Last Name: First: MI:
Date of Birth: Age: □ Male □ Female	Date of Birth:
Social Security #: □ Married □ Single □ Divorced □ Widowed	Last 4 of Social Security #:
Race/Ethnicity: _____ ❑ Declined to answer	
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Cell:	Home Phone: Cell:
Employer: Phone:	Employer: Phone:
Patient's E-mail Address:	

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____ Daytime Phone: _____

Do you have a DPOA or Legal Guardian? □ No □ Yes *(If yes, please provide the proper legal documents)*

Is this a Worker's Compensation case? □ Yes □ No Is this an automobile injury case? □ Yes □ No

Is this a personal injury case? □ Yes □ No

Primary Care Physician	**Referring Physician**
Name:	Name:
Address:	Address:
Phone:	Phone:
Primary Medical Insurance	**Secondary Medical Insurance**
Company:	Company:
Address:	Address:
Subscriber's Name:	Subscriber's Name:
Last 4 of SSN: Policy #:	Last 4 of SSN: Policy #:
Employer:	Employer:
Group #:	Group #:

Occupation (if retired, list previous occupation): _____

Hand Dominance □ Right □ Left □ Ambidextrous

HEALTH HISTORY

Past Medical History

Please put a check mark in the box under No or Yes to indicate whether you have been diagnosed with the condition or have been prescribed the medication.

	NO	YES
Aneurysm		
Atherosclerotic Disease		
Bleeding/Ulcer		
Cancer		
Coumadin/Warfarin		
Aspirin		
Plavix		
Statin		
DVT/Blood Clot		
Clotting Disorders		
Diabetes		
Ear/Nose/Throat		
Emphysema/COPD		
Heart Attack/MI		

	NO	YES
Heart Failure/CHF		
Hypertension		
High Cholesterol		
Infectious Disease		
HIV		
Hepatitis A/B/C		
Neurological		
Neuropathy		
Psychological		
Stroke/CVA/TIA		
Thyroid		
Varicose Veins		
Musculoskeletal		
Swelling		

Past Surgical History

Please add the date/comments for any of the following surgeries you have had and list any additional surgeries with an approximate date of the procedure.

Date	Type	Comments
	Heart Bypass	
	Leg Bypass R/L	
	Vein Surgery R/L	

Family History

Please mark any of the following conditions that have run in your family.

	Father	Mother	Brother(s)	Sister(s)	Other
Cancer					
Diabetes					
High Blood Pressure					
Heart Problems					
Aneurysms					
Stroke					
Varicose Veins/Spider Veins					
Leg Ulcers					
Swollen Legs					

Social History

	No	YES, how often? If you quit, please list approximate date.
Use tobacco?		
Drink alcohol?		
Current on immunizations?		
Do you live alone?		
Do you exercise?		
Do you consume caffeine?		

Medications/Allergies

Do you have ALLERGIES to Tape, Substances or any Medications? □ YES □ NO

If "YES", list allergies: _____

Current Medications/Supplements *We will be happy to photocopy your list, if available*.

Medication Name	Dose	Frequency

Pharmacy name & address: _____ **Phone**: _____

If needed, do we have your permission to retrieve your medication history to check for potential drug interactions? □ Yes □ No

Leg Evaluation

1. Have you ever had any of the following? *(Circle all that apply)*
   Vein stripping surgery? No Yes/Approx date_____ Right Leg Left Leg Both
   Vein Injection? No Yes/Approx date_____ Right Leg Left Leg Both
   Phlebitis? No Yes/Approx date_____ Right Leg Left Leg Both

2. Do you experience any of the following in your legs? *(Circle all that apply)*
   Aching/pain No Yes: Right Leg Left Leg Both Legs
   Heaviness No Yes: Right Leg Left Leg Both Legs
   Tiredness/fatigue No Yes: Right Leg Left Leg Both Legs
   Itching/burning No Yes: Right Leg Left Leg Both Legs
   Swelling No Yes: Right Leg Left Leg Both Legs
   Cramps No Yes: Right Leg Left Leg Both Legs
   Restless legs No Yes: Right Leg Left Leg Both Legs
   Bleeding No Yes: Right Leg Left Leg Both Legs
   Other: _____

3. Have your veins gotten worse in recent months? No Yes
   If yes, describe: _____

4. Do you take any medication for pain (ex. Advil, Motrin)? No Yes
   If yes, what medications do you take and how many times/mgs per day? _____

5. Do you elevate your legs to relieve discomfort? No Yes
   If yes, how long per day do you elevate and does it provide relief? _____

6. Do you wear prescription compression stockings? No Yes
   If yes, what type and gradient? _____
   How long have you worn them? _____

7. Do you wear light support hose (ex. Sheer Energy)? No Yes
   If yes, do they provide relief?

8. Do you have problems walking? No Yes
   If yes, describe how it interferes with your activities of daily living:

   _____

9. Have you ever had any tests done on your veins? No Yes
   If yes, when and what type of test? _____

10. Have you been under a physician's care for treatment of this condition? No Yes

    If Yes please list how long and the name of the provider _____

    _____