PATIENT ASSESSMENT

Name: ______________________________ DOB: _________________ SSN: __________________________

Home Phone: ______________________ Cell: __________________ Work Phone:__________________

Address: ____

City/Town: ________________________ State: _________________ Zip code:______________________

Sex: M F Height:________________ Weight: ______________________

E-mail Address: ____

If you do not wish to share your email or if you do not have an email, please initial ___________________________

Language: _________________________ **Race:** ________________________ **Ethnicity:** _________________________

Work, circle one: F/T P/T Retired Unemployed Disabled

Marital Status, circle one: Single Married Divorced Widowed Other

Emergency Contact:

Name: _________________________________ Relation: _____________ Phone #: __________________________

Primary Care Physician: ____

Address: ____ Phone #: __________________________

Referring Physician: ____

Address: ____ Phone # ___________________________

How did you hear about us?

☐ **TV** ☐ **Radio** ☐ **Internet** ☐ **Groupon** ☐ **Friend** ☐ **Event:** _______________ ☐ **Other**: _________________

Are you seeking treatment for:

_____ Cosmetic reasons _____ Medical reasons _____ Both

TURN →

What is your occupation? ______________________________

Does work require:

Prolonged sitting Yes No Prolonged standing Yes No

INSURANCE INFORMATION

Primary Insurance: ______________________________ **Copay Amount:** ______________________________
Identification #: ______________________________ **Group #:** ______________________________
Policy Holder: ______________________________ **DOB:** ______________________________
Employer: ______________________________ **Employer's Address:** ______________________________

Secondary Insurance: ______________________________ **Copay Amount:** ______________________________
Identification #: ______________________________ **Group #:** ______________________________
Policy Holder: ______________________________ **DOB:** ______________________________
Employer: ______________________________ **Employer's Address:** ______________________________

Insurance Referral Required: Yes___ No___ Obtained: Yes____ No____

Guarantor: ______________________________

WHICH LEG ARE YOUR COMPLAINTS LOCATED IN? (check one) ☐ Right ☐ Left ☐ Both

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (check all that apply)

☐ Aching ☐ Edema ☐ Tenderness

☐ Awakened at night ☐ Fatigue ☐ Throbbing

☐ Bleeding from veins ☐ Heaviness ☐ Ulcers

☐ Bulging ☐ Itching ☐ Varicose Veins

☐ Burning ☐ Painful ☐ Spider Veins

☐ Cramping ☐ Restless Legs ☐ Skin discoloration

☐ Difficulty healing wounds ☐ Swelling ☐ Other: ______________________

WHERE ARE YOUR SYMPTOMS LOCATED? (check one)

☐ Whole Leg ☐ Thigh ☐ Knee ☐ Calf ☐ Ankle ☐ Buttocks ☐ Groin ☐ Other:____________

WHEN DO YOUR SYMPTOMS OCCUR? CHOOSE THE BEST ANSWER BELOW. (check one)

☐ Mostly at nighttime ☐ All day ☐ Only during the day

☐ While laying down ☐ At bedtime Other: __________________

HOW LONG HAVE YOUR SYMPTOMS BEEN BOTHERING YOU? (fill in a number)

_______weeks _______months _______years

ARE YOUR SYMPTOMS WORSE IN ONE LEG THAN THE OTHER? (check one)

Worse in the right leg ☐ Worse in the left leg ☐ Equal in both legs

DO YOUR SYMPTOMS AFFECT YOUR ACTIVITIES OF DAILY LIVING? Yes or No

If yes, which activities are affected: (check all that apply)

☐ Exercise ☐ Unable to stand Long ☐ Homemaking
☐ Unable to walk hills ☐ Unable to sit long
☐ Walking ☐ Unable to work ☐ Sleep / Relaxation
Other: _______

ARE YOUR SYMPTOMS WORSENED BY: (check all that apply)

☐ Prolonged standing ☐ Working ☐ Premenstrual
☐ Prolonged sitting ☐ Heat ☐ Pregnancy
☐ Walking ☐ Hot bath ☐ Travel
☐ Exercise ☐ Resting ☐ Other____________

IF YOU HAVE VARICOSE VEINS, WHEN DID THEY OCCURE? Age____

Before Pregnancy____ After Pregnancy____ After Trauma/Surgery____ None of the above ____

ARE YOUR VEINS GETTING LARGER? YES____ NO____

DO YOU HAVE ULCERS? YES___NO____ **WHICH LEG?** RIGHT___LEFT___

IF YES, HOW LONG HAVE YOU HAD THEM?

RIGHT LEG: ☐______days ☐______months ☐______years ☐ N/A

LEFT LEG: ☐______days ☐______months ☐______years ☐ N/A

PLEASE MARK ANY CONSERVATIVE THERAPY MEASURES THAT YOU HAVE TRIED IN THE PAST TO RELIEVE YOUR SYMPTOMS: (check all that apply)

☐ Compression stockings ☐ Weight reduction ☐ Cold soak ☐ Walking
☐ Leg elevation ☐ Avoid prolonged sitting ☐ Warm soak ☐ Pain medications
☐Exercise ☐ Avoid prolonged standing ☐ Other: ______

If yes to compression stockings:

Compression	How Long?	Length		Worn When?	
☐ Store bought	____weeks	☐ Knee High	☐ Night Only	☐ Exercising	☐ Prior EVLA
☐ 20 - 30 mm Hg	____ months	☐ Thigh High	☐ All Day	☐ Traveling	☐ Prior Sclero
☐ 30 - 40 mm Hg	____ years			☐ Working	☐ Prior Surgery

If yes to pain medications: (check all that apply)

☐ Rx Meds (include in medication list) ☐ Naproxen(Aleve) ☐ Ibuprofen (Advil/Motrin)

☐ Acetaminophen (Tylenol) ☐ Aspirin

HOW OFTEN HAVE YOU USED MEDICATION? (check all that apply)

☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly

☐ 0-2 days/wk ☐ 3-4 days/wk ☐ 5-6 days in 2 wk period ☐ 7 > days in 2 wk period

WAS THERE RELIEF FROM SYMPTOMS WITH THE ABOVE CONSERVATIVE THERAPY MEASURES?

☐ Yes ☐ No

HAVE YOU HAD ANY VEIN TREATMENTS PERFORMED IN THE PAST? Yes or No

If yes, please list them below:

Previous Treatments:	**Location:** (Circle)	**Side:** (Circle)	**Year**	**Doctor**
☐ Endovenous Ablation	Front / Back	Right / Left	_______	____________________________
☐ Radio frequency Ablation	Front/ Back	Right / Left	_______	____________________________
☐ Sclerotherapy/Injections	Front / Back	Right / Left	_______	____________________________
☐ Stab Phlebectomy	Front / Back	Right / Left	_______	____________________________
☐ High Flush Ligation/Stripping	Front / Back	Right / Left	_______	____________________________
☐ Treatment for ulcers, phlebitis, cellulitis or edema	Type: ____________________________			
☐ Deep vein thrombolysis	Type: ____________________________			

PAST MEDICAL HISTORY: (check all that apply)

☐ Phlebitis
☐ Varicose Veins
☐ Spider Veins
☐ Bleeding Veins
☐ Leg Ulcers
☐ Leg Swelling/Edema
☐ Blood Clots
☐ Arterial Disease/Blockage
☐ Currently Pregnant/Planning
☐ Bleeding Disorder
☐ Pulmonary embolism (PE)
☐ SVT (superficial phlebitis)
☐ Trauma/Injury to Leg
☐ Migraine Headaches
☐ Asthma
☐ Blood born infectious disease
☐ Arrhythmia
☐ CVA/Stroke
☐ Hypertension
☐ Heart Problems
☐ HIV/AIDS
☐ Arthritis
☐ Bleeding Disorder
☐ Muscular Disease
☐ Hormonal Therapy
☐ Diabetes
☐ Seizures
☐ Cancer: ____________________
☐ Inability to donate blood
☐ Hepatitis
☐ Liver Disease
☐ Kidney Disease
☐ Hyper/Hypothyroidism
☐ Bleeding Disorder
☐ Other: ____

PAST SURGICAL HISTORY: (check all that apply)

☐ Adenoidectomy	☐ Lung Resection	☐ Breast Biopsy/Mastectomy	☐ Skin Cancer
☐ Colon Resection	☐ Hernia Repair	☐ Hip Replacement	☐ Breast Augmentation
☐ Appendectomy	☐ Prostate	☐ Knee Replacement	☐ Tummy Tuck
☐ Gall Bladder	☐ Hysterectomy	☐ Thyroid Surgery	☐ Liposuction
☐ C-Section	☐ Tubal Ligation	☐ Tubal Ligation	☐ Face Lift
☐ Bypass	☐ Other: ______________________________		

Any surgical complications?

____

____

FAMILY HISTORY OF VARICOSE VEINS? Yes or No

If yes, which family members: (check all that apply)

☐ Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather

FAMILY HISTORY OF CLOTTING DISORDER? Yes or No

If yes, which family members: (check all that apply)

☐ Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather

SMOKING STATUS:

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never

If you are a current or former smoker, how many packs per day? ________________

How long did you smoke regularly? ______________years

At what age did you start smoking?______________years

HOW MANY PREGNANCIES HAVE YOU HAD?__________(number)

HOW MANY MISCARRAGES? _________ (number)

HOW MANY CHILDREN DO YOU HAVE? _____ (number)

ALLERGIES TO:

Latex	Yes	No
Iodine/betadine	Yes	No
Tape/adhesives	Yes	No

PLEASE LIST ADDITIONAL ALLERGIES:

____

____

____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (including Herbs, Vitamins, Supplements, etc.)

NAME OF MEDICATION	DOSE/FREQUENCY	REASON YOU ARE TAKING

PLEASE MARK ANY ADDITIONAL SYMPTOMS YOU ARE EXPERIENCING TODAY OR RECENTLY:

☐ Fatigue
☐ Fever
☐ Recent Weight Loss
☐ Recent Weight Gain
☐ Disturbance of Vision
☐ Loss of Vision
☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath with activity
☐ Shortness of Breath at rest
☐ Swelling of Legs & Ankles
☐ Cold Sores
☐ Hoarse Voice
☐ Sinus Problems
☐ Sore Throat
☐ Chronic/Frequent Cough
☐ Cough/Spit Up Blood
☐ Wheezing
☐ Abdominal Pain
☐ Black Tarry Stools
☐ Difficulties/Painful Swallowing
☐ Heartburn
☐ Nervousness
☐ Hemorrhoids
☐ Indigestion
☐ Jaundice
☐ Rectal Bleeding
☐ Vomiting of Blood
☐ Joint Pain
☐ Leg Cramps
☐ Easy Skin Bruising
☐ Hair Loss
☐ Skin Itching
☐ Skin Rashes
☐ Skin Lesions
☐ Ulcers
☐ Difficulty Speaking
☐ Abnormal Numbness
☐ Dizziness
☐ Drooping of the Face
☐ Frequent Headaches
☐ Fainting Spells
☐ Drooping of the Face
☐ Fainting Spells
☐ Heartburn
☐ Other: ____
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Blood in Urine
☐ Irregular Periods
☐ Pain/Burn Urination
☐ Pain w/Menstruation
☐ Pelvic Pain
☐ Vulvar/Vaginal Veins
☐ Cold Intolerance
☐ Excessive Thirst
☐ Excessive Urination
☐ Heat Intolerance
☐ Incontinence
☐ Fainting Spells
☐ Recurring Infections
☐ Difficulty Speaking
☐ Abnormal Numbness
☐ Dizziness
☐ Frequent Headaches
☐ Fainting Spells
☐ Leg Weakness

By signing below, I acknowledge that the information I have provided is correct to the best of my ability.

Patient Signature:____ Date:_____/____/ ____

Authorization for Payment/Financial Agreement

I agree to pay International Vein Clinics (IVC) and The Vascular Experts of Southern Connecticut Vascular Center (TVE) for all services provided to me, and for any other applicable charges. I authorize and direct my insurance carrier to make payment to IVC/TVE of all insurance benefits. I agree to pay any remaining balance not covered by my insurance plan. If I receive payment from my insurance company or other third party payor for services provided to me by IVC/TVE, I agree to submit the payment to IVC/TVE. If my bill is not paid in full, IVC/TVE reserve the right not to provide any future non-emergency medical services to me.

Disclosures to Family Members, Friends and Personal Representatives

I understand that HIPAA allows me to name a family member(s), friend or any other person I identify as someone to whom IVC/TVE may disclose my personal health information. I understand that such disclosures shall be limited to the health information that is directly relevant to the named person's involvement with my healthcare or payment for my healthcare. I also understand that IVC/TVE will follow stringently the guidelines set forth by HIPAA under the policies and procedures as outlined in the "Disclosures to Family Members, Friends and Personal Representatives" guidelines and that if I request one, IVC/TVE will provide me with a copy of these guidelines for reference purposes.

Communications via Cellular Phone and/or Email

If you have provided a cellular telephone number and/or email address as a primary contact method. I hereby authorize, IVC/TVE, along with respective employees, agents and business associates, to contact me via cellular phone, text message or email for any reason. Including, without limitation, feedback surveys, automated notifications, appointment reminders, health wellness and prevention opportunities. Debt collection agencies may engage, to place calls to your designated cellular or residential phone, the use of any type of artificial or pre-recorded voice or auto-dialer technologies for any purpose permitted by law.

Please Sign: ____