

Date:

PATIENT INFORMATION		
First Name:	Last Name:	M.I.:
Home Address:		Apt #:
City:	State:	Zip:
Home Phone: ()	Work Phone: ()	Ext:
Cell/Other Phone: ()	Email:	
Date of Birth: / /	Marital Status:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Emergency Contact (Name & Phone):		

REFERRAL SOURCE	PREVIOUS TREATMENT
Whom may we thank for referring you to our practice? Name/Source: _____ Phone: () _____ Address: _____	Have you ever had your veins treated? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where did you receive treatment? Have you tried trial conservative therapy before? (Compression stockings, elevation, anti-inflammatories) <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL CONDITIONS			
Do you or any of your family members have a history of any of the following:			
<input type="checkbox"/> Blood Clots/DVT	<input type="checkbox"/> Heart Murmur/M.V.P.	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Clotting Abnormalities	<input type="checkbox"/> Diabetes I or II	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Other: _____
Allergies:	<input type="checkbox"/> Latex	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Adhesive
	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other: _____
Women:	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications: (Please list all medications and vitamins you are taking)			
Briefly explain your problem:			