Vein Specialists of Northwest Georgia, P.C.
PATIENT MEDICAL HISTORY INFORMATION

**Note: There are two sides to this form. Please be as complete and specific as possible.

Patient Name: _____ Referring Doctor: _____ Chart no: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Date of Visit: _____

Reason for today's visit: _____

PAST MEDICAL HISTORY Please check if you have, or have ever had:

☐ High blood pressure ☐ Heart disease ☐ Heart attack ☐ Congestive heart failure ☐ COPD ☐ Asthma
☐ Stroke/TIA ☐ Thyroid disease ☐ HIV/AIDS ☐ Hepatitis ☐ Kidney disease ☐ Arthritis
☐ Diabetes ☐ Seizures ☐ Cancer of _____ ☐ Other _____

Venous and bleeding/clotting history:

☐ Varicose veins ☐ Spider veins ☐ Leg ulcers ☐ Phlebitis ☐ Excessive bleeding ☐ Coumadin use ☐ Aspirin use
☐ Deep vein thrombosis or pulmonary embolus ☐ Other _____

PAST SURGICAL HISTORY (include year of procedure):

_____ _____
_____ _____
_____ _____

Past venous surgical history:

☐ Vein stripping ☐ Vein ligation ☐ Stab phlebectomy ☐ Vein closure ☐ Vein injections

When, where and on which leg was this performed? _____

CURRENT MEDICATIONS (include name and dose) _____

DRUG ALLERGIES _____

SOCIAL HISTORY (Please check all that apply):

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children (ages) _____

☐ Smoke _____ packs per day for _____ years. ☐ Drink alcohol. How much? _____

Occupation _____

Has anyone in your family ever had any of the following conditions? (Indicate Relationship)

							Maternal		Paternal	
			Mother	Father	Brother	Sister	Grmother	Grfather	Grmother	Grfather
Cancer	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Aneurysm	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Clotting problems	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐ Yes	☐ No	☐	☐	☐	☐	☐	☐	☐	☐

Do you have, or have you recently had, any of the following?

General
Fever . . . . . ☐ Yes ☐ No
Chills . . . . . ☐ Yes ☐ No
Fatigue . . . . . ☐ Yes ☐ No
Weight gain . . . . . ☐ Yes ☐ No
Weight loss . . . . . ☐ Yes ☐ No

ENT
Visual loss . . . . . ☐ Yes ☐ No
Hearing loss . . . . . ☐ Yes ☐ No
Mouth Sores . . . . . ☐ Yes ☐ No
Swallowing difficulties . . . . . ☐ Yes ☐ No

Cardiac
Chest pain . . . . . ☐ Yes ☐ No
High blood pressure . . . . . ☐ Yes ☐ No
Irregular heart beat . . . . . ☐ Yes ☐ No
Palpitations . . . . . ☐ Yes ☐ No
Swelling of arms or legs . . . . . ☐ Yes ☐ No

Respiratory
Chronic cough . . . . . ☐ Yes ☐ No
Shortness of breath . . . . . ☐ Yes ☐ No
Coughing up blood . . . . . ☐ Yes ☐ No

Gastrointestinal
Abdominal pain . . . . . ☐ Yes ☐ No
Nausea/vomiting . . . . . ☐ Yes ☐ No
Constipation . . . . . ☐ Yes ☐ No
Diarrhea . . . . . ☐ Yes ☐ No

Vascular
Pain in legs with walking . . . . . ☐ Yes ☐ No
Pain in legs at rest . . . . . ☐ Yes ☐ No
Vascular testing _____
Varicose veins . . . . . ☐ Yes ☐ No
Leg ulcers . . . . . ☐ Yes ☐ No

Hematologic
Blood clots . . . . . ☐ Yes ☐ No
Enlarged lymph nodes . . . . . ☐ Yes ☐ No
Prolonged bleeding . . . . . ☐ Yes ☐ No

FOR OFFICE USE ONLY

Date form reviewed _____

Initials of reviewer _____

Genitourinary
Blood in urine . . . . . ☐ Yes ☐ No
Recurrent UTIs . . . . . ☐ Yes ☐ No
Number of pregnancies . . . . . _____

Musculoskeletal
Back pain . . . . . ☐ Yes ☐ No
Joint pain . . . . . ☐ Yes ☐ No
Muscle cramps/pain . . . . . ☐ Yes ☐ No
Past injuries _____

Integumentary
Rash . . . . . ☐ Yes ☐ No
Sores . . . . . ☐ Yes ☐ No
Discoloration . . . . . ☐ Yes ☐ No
Healing problems . . . . . ☐ Yes ☐ No

Neurologic
Frequent headaches . . . . . ☐ Yes ☐ No
Arm/leg weakness . . . . . ☐ Yes ☐ No
Seizures . . . . . ☐ Yes ☐ No
Numbness/tingling . . . . . ☐ Yes ☐ No
Difficulty speaking . . . . . ☐ Yes ☐ No
Burning of toes, feet, hands . . . . . ☐ Yes ☐ No

Endocrine
Appetite changes . . . . . ☐ Yes ☐ No
Heat intolerance . . . . . ☐ Yes ☐ No
Cold intolerance . . . . . ☐ Yes ☐ No
Excessive thirst . . . . . ☐ Yes ☐ No

Psychiatric
Depression . . . . . ☐ Yes ☐ No
Anxiety/nervousness . . . . . ☐ Yes ☐ No
Insomnia . . . . . ☐ Yes ☐ No

I have tested positive for the following (please check any that apply):

☐ HIV ☐ Hepatitis B ☐ Hepatitis C
☐ C-Diff ☐ Other (specify) _____

_____
Patient Signature **Date**

Print name _____

VEIN SPECIALISTS OF NORTHWEST GEORGIA
VASCULAR SURGICAL ASSOCIATES, P.C.

Patient Questionnaire: Veins

Patient Name:_____

Today's Date:_____**Patient Date of Birth:** _____ **Chart#:**_____

**Please fill out form completely. This will be included in the paperwork sent to your insurance company requesting approval for varicose vein treatment.

Which leg is bothering you today?

Right leg	Both legs, right worse than left
Left leg	Both legs, left worse than right
Both legs symmetrically	

How long have you had :
Varicose Veins ? _____
Swelling? _____
Open wounds? _____

Have you ever used any of the following conservative treatments for varicose veins?

1. **Prescription compression hose?** **YES NO**
   - What grade/strength compression? (Please circle one)
     20-30mmHg 30-40mmHg 40+mmHg unsure
   - How long have you used compression hose? _____

2. **Do you elevate your legs to reduce discomfort?** **YES NO**
   -If yes, how long have you tried this? _____

3. **Have you tried exercise to help relieve your symptoms?** **YES NO**
   -If yes, what have you tried? _____
   -For how long? _____

4. **Have you tried any medications to reduce pain or discomfort from your legs?**
   -If yes, what have you tried? _____
   (EXAMPLES: MOTRIN, ADVIL, TYLENOL or PRESCRIPTION MEDS)
   -For how long? _____

Despite conservative measures do you have any of the following: (Please circle any that apply)

Bulging veins	Aching	Recurrent superficial phlebitis	
Discolored veins	Burning	Hemorrhage/Bleed from varicose vein	
Spider veins	Itching	Muscle Cramps	
Skin color changes	Heaviness	Leg fatigue	
Ulcerations	Throbbing	Stinging	
Leg pain	Sharp pain	Leg swelling	Dull pain

Patient Signature:_____**Date**_____

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Surgery Cancellation Policy

We understand that sometimes it may be necessary to reschedule a procedure due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused procedure time in which other patients could benefit , and loss of valuable, productive time by our physicians. Your insurance authorization may be affected as well. There is typically a time frame that insurance companies allow to have surgical procedures done and if it is rescheduled, we can not always guarantee that they will extend that time frame.

Therefore, in order for us to maintain efficiency, as well as give full consideration to our patients and physicians, it is necessary for us to implement a cancellation policy.

If you need to cancel or reschedule your procedure, we ask that you do so in a timely manner. A minimum of 48 hours notification is required in order to avoid a cancellation fee.

Failure to notify us of cancellation in the required time will result in a charge of $150.

Exceptions to this policy may be made for emergencies and conflicts beyond your control.

We thank you for your understanding and co-operation.

I have read this policy and understand that cancellation of my procedure may result in a fee of $150.

_____

Patient Name

_____ _____

Guarantor Signature **Date**