Vein Specialists OF AUGUSTA
Therapeutic & Cosmetic Vein Care
Zumbro Vein Institute

NEW PATIENT INFORMATION RECORD

PATIENT INFORMATION

501 Blackburn Drive
Martinez, GA 30907
706-854-8340
Fax: 706-854-8341
www.VeinsAugusta.com

First Name: _____ Last Name: _____ MI: ___

Social Security #: _____ Birth Date: _____ Age: _____

Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone:_____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about us? TV Radio Newspaper Yellow Pages Other

Primary Physician: _____

INSURANCE INFORMATION

Person responsible for bill: _____ Birth date: _____

Address (if different): _____ Home phone: _____

Employer: _____ Employer Address: _____ Employer Phone: _____

Please indicate primary insurance: (circle one) **Private Insurance** **Medicare** **Medicaid**

Subscriber's Name: _____ Subscriber's SS #: _____ Birth Date: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's Name: _____

All co-payments and deductibles will be collected at the time of visit. Your co-pay only covers your office visit. Any procedures are subject to your yearly deductible.

IN CASE OF EMERGENCY

Name of local friend or relative: _____ Relationship to patient: _____

Home phone: _____ Work phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vein Specialists of Augusta or insurance company to release any information required to process my claims.

Patient signature: _____ Date: _____

HISTORY/MEDICATIONS/PRE-ANESTHESIA EVALUATION

VEIN SPECIALISTS OF AUGUSTA

Name _____ Date of Birth _____ Sex ☐ M ☐ F Age _____

Date of Surgery _____ Surgeon _____ Height _____ Weight _____

Primary Care Physician _____ Physician Phone Number _____

Do you currently have or have you ever had:

Eyes/Ears:

Yes No

❑ ❑ History of injury – type _____
❑ ❑ Glaucoma
❑ ❑ Hearing loss
On which side do you hear best? _____
❑ ❑ Hearing aids? R or L

Endocrine:

❑ ❑ Thyroid: Hyper or Hypo
❑ ❑ Diabetes – Insulin, pills, or diet controlled

Cardiovascular:

❑ ❑ High Blood Pressure
❑ ❑ Peripheral vascular disease
❑ ❑ Atrial Fibrillation
❑ ❑ Heart attack – when _____
❑ ❑ Murmur/history of Rheumatic fever
❑ ❑ Chest pain/Angina – how often _____
If yes, how treated _____
❑ ❑ Palpitations
❑ ❑ Pacemaker/Implanted defibrillator
❑ ❑ History of Congestive heart failure

Respiratory:

❑ ❑ Asthma – last ER visit _____
❑ ❑ COPD
❑ ❑ Sleep Apnea
❑ ❑ CPAP/BIPAP
❑ ❑ Tuberculosis – treatment _____
❑ ❑ Shortness of breath
❑ ❑ Can you walk a flight of stairs without stopping?

Gastrointestinal:

❑ ❑ Hiatal Hernia
❑ ❑ Acid Reflux (GERD)
❑ ❑ Hepatitis
❑ ❑ Jaundice
❑ ❑ Cirrhosis

Musculoskeletal:

❑ ❑ Arthritis: Rheumatoid or Osteoarthritis
❑ ❑ Back pain or Neck pain
❑ ❑ Difficulty walking

Hematologic:

❑ ❑ HIV+
❑ ❑ Anemia/Sickle cell – disease or trait
❑ ❑ Bleeding/Easy bruising
❑ ❑ Blood thinners
❑ ❑ History of blood clots

Genitourinary:

Yes No

❑ ❑ Kidney Disease
❑ ❑ Dialysis: Hemo/peritoneal – M T W Th F
❑ ❑ Overactive Bladder/Incontinence
❑ ❑ Prostate problems

Neurological:

❑ ❑ Stroke or TIA
when _____
how was it treated _____
❑ ❑ Paralysis – where _____
❑ ❑ Parkinson's Disease
❑ ❑ Muscle weakness
❑ ❑ Alzheimer's or Senile Dementia
❑ ❑ Epilepsy – last seizure _____
❑ ❑ Restless leg syndrome

Females:

❑ ❑ Are you pregnant
Last menstrual period _____
Birth control method _____

Other:

❑ ❑ Problems with Anesthesia _____
❑ ❑ Cancer – what type _____
current treatment _____
❑ ❑ Mastectomy: L or R When _____
❑ ❑ History of smoking – how long _____
❑ ❑ Alcohol use – how much _____
❑ ❑ Substance abuse _____
❑ ❑ Contact lenses – removed _____
❑ ❑ Other conditions not listed _____
_____

Please list all surgeries with approximate dates: _____

_____

_____

_____

Signature: _____

Date completed: _____

Phone number: _____

MEDICATIONS/ALLERGIES

VEIN SPECIALISTS OF AUGUSTA

Allergies to Medications/Foods: ❑ None Known

_____

_____

_____

_____

_____

Allergic to: ❑ Latex/Rubber ❑ Betadine/Iodine

Medication Information Obtained From:

❑ Patient ❑ Family ❑ List/Card

Patient Sticker

(Office Use Only)

MEDICATION LIST

(Please include all prescriptions, over-the-counter, herbal remedies, vitamins, dietary supplements)

(staff use only)

Medication	Dose	How it is Taken	How Often	Last Dose

❑ Medications/Allergies Verified

Staff Signature: _____

Date _____

Vein Problem and Treatment History

1. How long have you had vein problems? _____

2. Do you experience any symptoms as a result of your veins?
   Please circle if applicable:

Sharp pain	Aching/discomfort	Heaviness
Swelling	Itching/burning	Throbbing
Congestion/pressure	Night cramps/restless legs	Tiredness

3. Have you ever had a leg ulcer? Yes No
If yes, which leg and when? _____

4. Do your symptoms mainly occur after being on your feet for long periods? Yes No

5. Are you typically on your feet for long periods of time? _____ Yes No

6. Have you ever had vein stripping/ligation surgery? _____ Yes No
If yes, which leg and when?_____

7. Have you ever had laser treatment of veins? _____ Yes No
If yes, which leg and when? _____

8. Have you ever had vein injections? _____ Yes No
If yes, which leg and when? _____

9. Have you ever had a blood clot? _____ Yes No
If yes, where, when, and how was it treated? _____

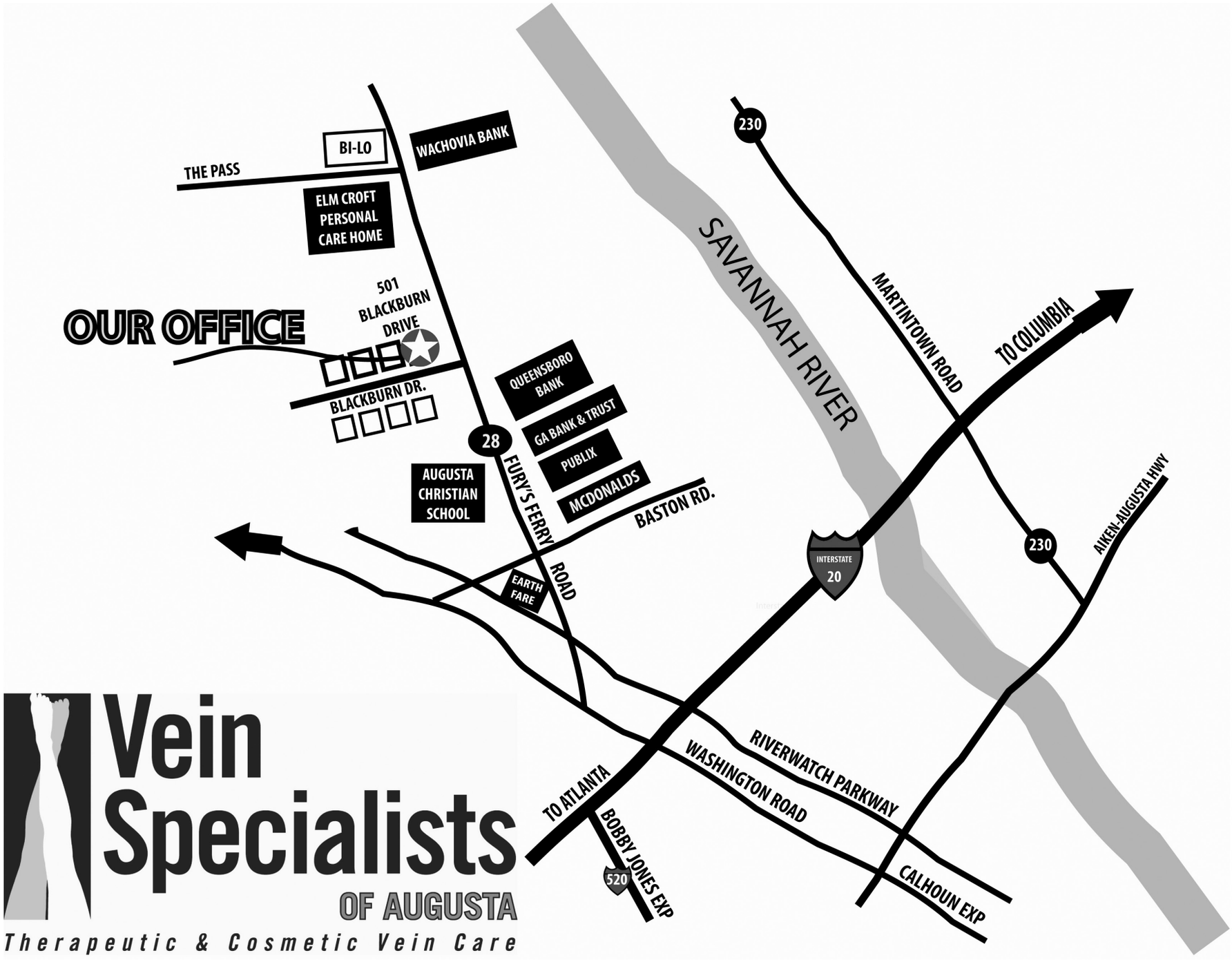
10. Have you ever had phlebitis (vein inflammation)? _____ Yes No
If yes, which leg and when? _____

11. Does anyone in your family have varicose veins, spider veins, leg ulcers, history of blood clots or swollen legs? Please circle if applicable:
Father Mother Brother Sister Other_____

12. Have you ever worn support/compression hose? Yes No

13. Do you have pain in your legs when you walk? Yes No

Patient Signature: _____



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