LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

DATE OF BIRTH: _____ AGE: ____ SOCIAL SECURITY # _____

MALE __ FEMALE __ MARITAL STATUS: M S D W OTHER_____

EMAIL ADDRESS_____ _____

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER: _____ WORK # _____

PRIMARY INSURANCE: _____ ID# _____

SECONDARY INSURANCE: _____ ID# _____

EMERGENCY CONTACT_____ PHONE # _____

PRIMARY PHYSICIAN/REFERRING PHYSICIAN: _____

DO YOU HAVE AN ADVANCE DIRECTIVE? (LIVING WILL): YES____ NO____

It is YOUR responsibility to know if your insurance requires a referral. If you do not obtain this referral before your visit, you will be responsible for the bill.

SIGNATURE: _____ DATE: _____

_____ (INITIAL) I request that payment of authorized insurance or Medicare benefits be made either to me or on my behalf to Steven T. Deak, M.D. for any services furnished to me by that physician. I authorize any holder of medical information about me, to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ (INITIAL) I authorize you to give my personal information to my spouse, grown children, or parents.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPPAA compliance officer in person or by phone at our main office number.

Signature below is acknowledgement that you have received this notice of our privacy practices:

SIGNATURE_____ DATE: _____

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VEIN SCREENING FORM
Please complete left side of form only.

Date: _____ Appt Time: _____ Screening Provider: _____

Name: _____ Primary Care Physician: _____

DOB: _____ Sex: ☐M ☐F Insurance Provider: _____

How did you hear about us? _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg: ☐R ☐L
Blood clots	☐Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg: ☐R ☐L
Heaviness	☐Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐Y ☐N	Leg: ☐R ☐L
Itching/burning	☐Y ☐N	Leg: ☐R ☐L
Swelling	☐Y ☐N	Leg: ☐R ☐L
Cramps	☐Y ☐N	Leg: ☐R ☐L
Restless legs	☐Y ☐N	Leg: ☐R ☐L
Throbbing	☐Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg: ☐R ☐L
Other:	☐Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What? _____
Elevation of legs	☐Y ☐N	What? _____
Wear support hose	☐Y ☐N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who? _____
Vein stripping	☐Y ☐N	Who? _____
Blood coagulation disorder	☐Y ☐N	Who? _____
Blood clots	☐Y ☐N	Who? _____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

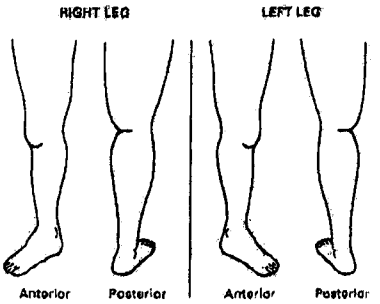
Sclerotherapy	☐Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐Y ☐N
Prolonged sitting periods	☐Y ☐N
Do you exercise regularly?	☐Y ☐N
Do you smoke?	☐Y ☐N
Pregnancies	☐Y ☐N How many? ___

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

LEFT LEG (check all that apply)

☐ No signs of venous disease ☐ Spider veins
☐ Visible varicose veins ☐ Edema
☐ Pigmentation ☐ Healed ulcers ☐ Active ulcers

Clinical Assessment:
☐ Chronic venous insufficiency ☐R ☐L
☐ Other: _____ ☐R ☐L

Treatment Plan:
☐ Duplex ultrasound ☐R ☐L
☐ Sclerotherapy ☐R ☐L
☐ Medical compression stockings ☐R ☐L
☐ Other: _____ ☐R ☐L

Screening Provider Signature: _____

Follow-Up Appointment
Date: _____ Time: _____
Physician: _____
Physician Phone Number:

NOTES:

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MEDICAL HISTORY

NAME:	DATE OF BIRTH:
REASON FOR VISIT:	
MEDICAL HISTORY (LIST ANY MEDICAL PROBLEMS):	
HAVE YOU HAD ANY SURGERIES? IF YES, PLEASE EXPLAIN:	
DO YOU TAKE ANY MEDICATIONS? IF YES, PLEASE LIST:	
DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE EXPLAIN:	
DO YOU SMOKE OR DRINK? IF YES, HOW OFTEN?	
PLEASE LIST SIGNIFICANT HEALTH ISSUES OR CAUSE OF DEATH OF YOUR MOTHER, FATHER, AND SIBLINGS:	

SIGNATURE_____ DATE: _____