Midwest Vein & Vascular Center Patient Health History Form

Have you ever had any of the following:	Right	Left	Both	Neither	If so, When?
An injury to either of your legs that required an operation or casting?					
A deep vein thrombosis (D.V.T.). Also known as a blood clot in your leg?					
Phlebitis?					
A Venous Stasis Ulcer?					
Hemorrhage from a Varicose Vein?					
Sclerotherapy?					
Vein stripping or Endovenous Ablation?					

Please answer the following very carefully, as it will help your insurance company decide if your vein problems are a covered benefit. In the last six months have you . . . .

. . .tried support stocking to relieve your vein problems without success?	Yes	No	. . .had to take time off work because of your vein problems?	Yes	No
. . .had to take pain medicine because of your vein problems?	Yes	No	. . .had to limit your activities and lifestyle because of your vein problems?	Yes	No

Please indicate if you have any of the following conditions by circling Yes or No:

Diabetes	Yes	No	Seizures	Yes	No
Heart Disease	Yes	No	Renal Failure	Yes	No
Lung Disease	Yes	No	Hepatitis	Yes	No
Hypertension	Yes	No	HIV Infection	Yes	No
Arthritis	Yes	No	Fainting	Yes	No
Cancer	Yes	No	Tobacco Use	Yes	No

Please indicate (by circling Yes or No) if you currently (or recently) were on any of the following:

Coumadin	Yes	No	Topical skin medications	Yes	No
Plavix	Yes	No	Antibiotics	Yes	No
Daily Aspirin	Yes	No	Steroids	Yes	No

For Women Only: Please indicate if Yes or No if you are . . .

Pregnant or think you might be?	Yes	No	Taking Oral Contraceptives?	Yes	No
Currently Nursing (Breast Feeding)?	Yes	No	On Hormone Replacement Therapy (HRT)?	Yes	No
Do you think you will have more children?	Yes	No	Do you anticipate starting HRT Soon?	Yes	No

How many times have you gone through childbirth?_____

(More questions are on the next page)

Patient Name:_____ Date:_____ Time:_____

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Tell us what kind of work you do by completing the following sentence:
I work as a/an. . . . ._____
(If you are retired, tell us what kind of work you did before retirement.)
In your own words, please describe the problem for which you are seeking our services:_____

We routinely send a report of our findings to your family doctor. If you prefer we not send a report, please check the box: ☐ Do not send report

Please give us the name/phone number of your family doctor:_____
Name Phone#
Please list all medications (including vitamins and supplements) that you take at least three times per week:

Are you allergic to anything? [ ]Yes [ ]No

If yes, please list any and all allergies:_____

Family History: Please indicate if any of the following conditions were present in your immediate family members:

Varicose Veins?	Yes	No
Venous Ulcers?	Yes	No
Deep Vein Thrombosis?	Yes	No

Phlebitis?	Yes	No
A history of Vein Surgery?	Yes	No
Blood Clots?	Yes	No

Past Surgical History:
Have you ever had surgery? [ ]Yes [ ]No

If you have had surgery, what type and when?_____

Additional Medical History Not Mentioned Above:
Are you presently seeing another physician for anything NOT mentioned above? [ ]Yes [ ]No

If so, What is the Doctors Name?_____

If so, For what condition(s) is he or she treating you?_____

Have you ever been hospitalized for anything NOT mentioned above? [ ]Yes [ ]No

If so, for what, at what Hospital, and when?_____

Patient Name:_____ Date:_____ Time:_____

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Review of Systems: Do you currently have any of the following?
If you check "Yes" for anything, explain on the line below the checkbox.

No	Yes	
		Constitutional: (Fevers, chills, recent unexplained loss of appetite or weight).
		Eyes:(Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting).
		ENT: (No recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears).
		Cardiac: (No chest pain, shortness of breath, waking from sleep breathless, or cardiac meds).
		Respiratory: (No shortness of breath, productive cough, coughing up blood, or pain with breathing).
		Gastrointestinal: (No change in bowel habits, no black, red or bloody stools, vomiting or belly pain).
		Genitourinary: (No incontinence, frequent, urgent or painful urination. No waking at night to urinate).
		Musculoskeletal: (No change in walking ability or strength. No painful joints)
		Skin: (No problematic rashes or itching, no changes in skin color or sores that won't heal)
		Neurological: (No unexpected, unexplained numbness, tingling, or loss of memory or movement).
		Psychiatric: (No suicidal thoughts or hallucinations)

Patient Name:_____ Date:_____ Time:_____

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Insurance Information:

When you arrive for your appointment, please provide our receptionist with your Drivers License, primary insurance card and secondary insurance card (if you have secondary insurance). We will make a copy of these cards and keep them in your file.

Please complete the following information, then sign and date below:

Name of Primary Insurance Company:_____

Is the above Primary Insurance Policy in your name? Yes☐ No☐

If the above primary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Name of Secondary Insurance Company:_____

Is the above Secondary Insurance Policy in your name? Yes☐ No☐

If the above secondary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder:_____

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Is there anyone you would like to give consent to speak on your behalf regarding your treatment, insurance coverage and/or account information? Please authorize by placing their name(s) here:

Name(s):_____ Your relationship:_____

Authorization: I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of medical benefits to the Physician of Midwest Vein Center for all professional goods and services rendered. I understand I am financially responsible for any charges whether or not covered by insurance.

Patient Signature:_____ Date:_____

Patient Name:_____ Date:_____ Time:_____