The Vein Treatment Center e.1982

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: ☐ M ☐ F
Emergency Contact (Name & Phone):		

REFERRAL SOURCE

Whom may we thank for referring you to our practice?

Name/Source: _____

Phone: ( ) _____

Address: _____

PREVIOUS TREATMENT

Have you ever had your veins treated?
☐ Yes ☐ No

If so, where did you receive treatment?

Have you tried trial conservative therapy before?
(Compression stockings, elevation, anti-inflammatories)
☐ Yes ☐ No

MEDICAL CONDITIONS

Do you or any of your family members have a history of any of the following:

☐ Blood Clots/DVT	☐ Heart Murmur/M.V.P.	☐ Cancer	☐ Epilepsy
☐ Clotting Abnormalities	☐ Diabetes I or II	☐ Hepatitis	☐ Anemia
☐ Blood Disorder	☐ High Blood Pressure	☐ AIDS/HIV	☐ Other: _____

Allergies:	☐ Latex	☐ Lidocaine	☐ Adhesive
	☐ Cortisone	☐ Penicillin	☐ Other: _____

Women:	Are you pregnant?	☐ Yes ☐ No
	Are you nursing?	☐ Yes ☐ No

Medications: (Please list all medications and vitamins you are taking)

Briefly explain your problem: