THE VEIN INSTITUTE
AT SOUTHERN SURGICAL ARTS

PATIENT INFORMATION FORM

Name: _____
Date of Birth: _____
Social Security No: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Place of Employment: _____
Home Address: _____
City: _____
Zip Code: _____
Spouse's Name: _____
Work Phone: _____
Email Address: _____
Place of Employment: _____

Nearest relative not living with you:
_____ Phone: _____

Whom may we contact in case of emergency?
_____ Phone: _____
Can we call you at work for routine matters? ☐ Yes ☐ No
Whom may we thank for referring you to us?
_____ Phone: _____
Who is responsible for the charges that may incur?
_____

INSURANCE INFORMATION

Primary Policy Name _____
ID No: _____ Group No: _____
Type of Insurance Plan: (HMO, PPO, POS) _____
Referral Needed? _____
Primary Policy Holder's Name: _____
Date of Birth: _____
Social Security No: _____
Place of Employment: _____

Secondary Policy Name _____
ID No: _____ Group No: _____
Type of Insurance Plan: (HMO, PPO, POS) _____
Referral Needed? _____
Primary Policy Holder's Name: _____
Date of Birth: _____
Social Security No: _____
Place of Employment: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this and subsequent sheets and have completed the answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient Signature or Parent (if minor): _____ Date: _____

1405 Cowart Street Suite 321 | Chattanooga, TN 37408 | Phone: 423.551.8346 | Fax: 423.551.8347

Name:_____ Age:_____

Date of Birth:_____ Today's Date:_____

Friends/Relatives who have seen us: _____

How did you hear about us? _____

Please list all doctors (and phone #s) you see or have seen:

Doctor that consulted Dr. Gardner: _____

Primary Care Physician: _____

Specialist Physicians: _____

PRIMARY REASONS FOR YOUR VISIT:

- ☐ Leg Edema/Swelling
- ☐ Varicose Veins
- ☐ Restless Legs
- ☐ Skin Discoloration/Thickening
- ☐ Leg Ulcers
- ☐ Leg Pain /Aching
- ☐ Cosmetic Appearance
- ☐ Other: _____

SIGNS/SYMPTOMS:

- ☐ Aching / Pain _____
- ☐ Tenderness _____
- ☐ Cramps _____
- ☐ Swollen Ankles _____
- ☐ Blood Clots _____
- ☐ Itching _____
- ☐ Tingling _____
- ☐ Heaviness _____
- ☐ Tiredness _____
- ☐ Phlebitis/Infection _____
- ☐ Redness _____
- ☐ Bleeding _____
- ☐ Skin Ulceration _____
- ☐ Varicose Veins _____
- ☐ Restless Legs _____
- ☐ Vaginal/Pelvic Discomfort _____
- ☐ Other _____

_____

_____

_____

_____

How many years have you had these symptoms? _____

What activity makes it worse?

- ☐ Prolonged Standing
- ☐ Work
- ☐ Prolonged Sitting
- ☐ Walking
- ☐ Housekeeping
- ☐ Yard Work
- ☐ Travel
- ☐ Exercise

What conservative measures have you tried?

- ☐ Leg Elevation _____
- ☐ Avoid Prolonged Standing _____
- ☐ Weight Reduction _____
- ☐ Compression Stockings _____
- ☐ Walking/Exercise _____
- ☐ Baths/Hot Soaks _____
- ☐ Pain Meds/Analgesics _____
- ☐ Other Measures: _____

_____

Have your veins been treated before? ☐ Yes ☐ No

☐ Stripping ☐ Injections ☐ Phlebectomy ☐ Laser

By Whom?_____ When?_____

ALLERGIES: ☐ None ☐ Yes

(If Yes, List the medication and reaction)

_____

_____

MEDICATIONS: (List all Medications, Dosages, and Frequency. Include over-the-counter medications and supplements.)

_____

_____

_____

_____

_____

_____

Physician Statement: *I have reviewed and summarized this form with the patient and family present.*

Med Asst/Physician: _____

Date: _____

Patient Statement: *I certify that, to the best of my knowledge, the information provided is accurate and complete.*

Signature: _____

Date: _____

CARDIAC Hx: YES/NO

- Cardiac Cath/When_____ ☐ ☐
- Heart Stent/When_____ ☐ ☐
- Heart Attack ☐ ☐
- Heart Bypass/When_____ ☐ ☐
- Heart Disease ☐ ☐
- Heart Failure ☐ ☐
- Heart Mitral Valve Prolapse ☐ ☐
- Heart Murmur ☐ ☐
- High Blood Pressure ☐ ☐
- High Cholesterol ☐ ☐
- Angina/Chest Pain ☐ ☐
- Pacemaker ☐ ☐

Cardiologist: _____

Other: _____

VASCULAR Hx: YES/NO

- Aneurysm/Type _____ ☐ ☐
- Blood Clots/DVT ☐ ☐
- Free Bleeding ☐ ☐
- Phlebitis/Vein Infection ☐ ☐
- Pulmonary Embolus ☐ ☐
- Restless Legs ☐ ☐
- Sickle Cell ☐ ☐
- Stroke/TIA ☐ ☐
- Warfarin Use ☐ ☐
- Coagulopathy: Type_____ ☐ ☐

Other: _____

MEDICAL Hx: YES/NO

- Arthritis ☐ ☐
- Anemia ☐ ☐
- Cancer/Type_____ ☐ ☐
- Diabetes Mellitus ☐ ☐
- Emphysema/Asthma/COPD ☐ ☐
- Fibromylgia ☐ ☐
- Hepatitis A/B/C ☐ ☐
- HIV/AIDS ☐ ☐
- Kidney Disease ☐ ☐
- Liver Disease ☐ ☐
- Migraines/Headaches ☐ ☐
- Sleep Apnea ☐ ☐
- Stomach Ulcers ☐ ☐
- Current Wheelchair Use ☐ ☐

Other: _____

LEG Hx: YES/NO

- Leg Infection ☐ ☐
- Leg Ulcers ☐ ☐
- Leg Trauma/Leg Injury ☐ ☐
- Lymphedema/Lymphangitis ☐ ☐
- Neuropathy ☐ ☐

Other: _____

GYNECOLOGIC Hx: YES/NO

- Pelvic Pain / Fullness ☐ ☐
- Pelvic Pain During Intercourse ☐ ☐
- Pelvic Pain w/ Menstrual Cycle ☐ ☐
- Pelvic Pain w/ Prolonged Study ☐ ☐
- Vulvar/Vaginal Varicosities ☐ ☐

Other: _____

FAMILY Hx:

- ☐ Restless Legs
- ☐ Varicose Veins
- ☐ Spider Veins
- ☐ Leg Ulcers
- ☐ Blood Clots
- ☐ Heart Disease
- ☐ Free Bleeding
- ☐ Cancer/ Type _____
- ☐ Stroke

Other: _____

SURGICAL Hx: YES/NO

- Back Operation ☐ ☐
- Hysterectomy ☐ ☐
- Leg/Knee/Hip Operation ☐ ☐
- Neck Operation ☐ ☐
- Pacemaker/ICD ☐ ☐
- Thyroidectomy ☐ ☐
- Vein Operation/When_____ ☐ ☐
- Artery Operation ☐ ☐
- Heart Operation ☐ ☐
- Previous Anesthesia Problems ☐ ☐

Other: _____

SOCIAL Hx:

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Children: _____

Next of Kin: _____

Family Here Today: _____

Cigarette Use: ☐ Never

- Age when Started _____
- PPD _____
- Quit/When _____

Alcohol Use: ☐ Never

- Age When Started _____
- Drinks Per Week _____
- Quit/When _____

Drug Use: ☐ Never

- Type and Frequency_____

_____

Quit / When_____

Occupation: _____

- ☐ Retired
- ☐ Disabled / Reason _____

REVIEW OF Sx's: YES/NO

What are you feeling currently?

Constitution

- Fever/Chills ☐ ☐
- Night Sweats ☐ ☐
- Fatigue ☐ ☐

Cardiovascular

- Chest Pain ☐ ☐
- Chest Pressure ☐ ☐
- Palpitations ☐ ☐

Musculoskeletal

- Joint Stiffness ☐ ☐
- Joint Pain ☐ ☐
- Back / Neck Pain ☐ ☐

Endocrine

- Excessive Thirst/Urination ☐ ☐
- Hormone Problems ☐ ☐
- Thyroid Disease ☐ ☐

Urinary

- Kidney Stones ☐ ☐
- Blood in Urine ☐ ☐
- Painful Urination ☐ ☐

Respiratory

- Shortness of Breath ☐ ☐
- Wheezing/Asthma ☐ ☐
- Heavy Snoring ☐ ☐

Neurological

- Convulsions/Seizures ☐ ☐
- Numbness/Tingling ☐ ☐
- Vertigo ☐ ☐

Hematologic

- Anemia ☐ ☐
- Free Bleeding ☐ ☐
- Sickle Cell ☐ ☐

Breast

- Breast Lumps / Pain ☐ ☐
- Nipple Discharge ☐ ☐

Last Mammogram: _____

Gastrointestinal

- Irritable Bowel Syndrome ☐ ☐
- Yellow Jaundice ☐ ☐
- Diarrhea ☐ ☐

Last Colonoscopy _____

Gynecologic

Number of Pregnancies _____

Number of Live Births _____

Hormone Therapy ☐ ☐

Type_____

Are You Breast Feeding? ☐ ☐

Are You Pregnant or Planning to be Soon? ☐ ☐