PINNACLE
VEIN & VASCULAR CENTER
THE PEAK OF GOOD HEALTH

New Patient Paperwork

Pinnacle Vein and Vascular Center
Phone: 1.888.553.VEIN(8346) | Fax: 623.404.4530
www.pinnaclevein.com

Patient Information:

Name: _____ Date of Birth: _____

Sex: _____ Race: _____ Marital Status: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work #: _____

Cell Phone: _____ Home Phone: _____

Best Contact: Home / Work / Cell / E-mail Email: _____

How Did You Hear About Us? _____

Referring Doctor: _____ Primary Physician: _____

Preferred Pharmacy: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Policy Holder SS #:_____ Policy Holder DOB:_____

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder: _____

Policy Holder SS #: _____ Policy Holder DOB: _____

Patient Signature: _____Date: _____

Past Surgical History: Please list any surgeries you have had, including previous vein treatment.

Drug Allergies: Please list any allergies to any medication

Medication	Dose	Frequency

Family History: Please list any relevant family history of medical illness or disease

Mother	
Father	
Sibling	

Past Medical History: Please mark all that apply

___ Abdominal Aortic Aneurysm	___Cancer	___ High Blood Pressure
___ Heart Disease	___Pacemaker	___ High Cholesterol
___ Congestive Heart Failure	___ Atrial Fibrillation	___ Lupus
___ COPD	___ History of DVT	___ Hepatitis B
___ Kidney Disease	___ History of PE	___ Hepatitis C
___ Renal Failure/ Dialysis	___ Depression	___ Thyroid Disease
___Bleeding or Clotting Disorder	___ Diabetes	___ Migraines
___ HIV or AIDS	___ Heart Attack	___ Other
___Arthritis	___ Stroke	_____

Current Symptoms: Please mark all that apply

___Blurred/Loss of Vision	___ Fatigue	___Abdominal Pain
___Dizziness/Vertigo	___Palpations	___Chest Pain
___Headaches	___Weight Gain	___Shortness of Breath
___Seizures	___Weight Loss	___ Other
___Anxiety	___ Allergies	_____
___Depression	____Joint Pain	_____

Are you currently on blood thinners? ____Yes _____No

If yes, for how long? _____

Social History:

Do you now or have you ever used tobacco? ___Yes ____No

Packs per day_____ Date quit, if applicable_____

Average number of alcoholic beverages per week: ___None ____ 1-5 ___ 6-10 ___ 10+

Females Only:

Are you pregnant or plan on becoming pregnant? ___Yes ___No

Are you currently breastfeeding? ___Yes ___No

Lower Extremity Vascular History

Only fill out this portion if you are being seen today for symptoms in your legs or Varicose Veins.

Do you have any of the following symptoms?

___Red/purple spider veins	___Bulging veins	___Calf/thigh/buttock pain
___Skin discoloration	___Venous ulcers/open wounds	___Black toe/Gangrene
___Leg pain	___Cramping	___Itching
___Swelling	___Burning	___Heaviness
___Bleeding from veins	___Restless legs	

Years with varicose veins? _____ Years with venous ulcers? _____

Please mark any factors that agitate your leg discomfort:

___Prolonged standing ___Tender to touch ___Walking, if yes

___Prolonged sitting ___Pregnancy distance walking before pain

___Exercise ___Around/during menstrual cycle _____

Please mark any methods you have used to relive pain:

___Compression hose/wraps ____Cold Compress ___Pain medication

___Exercise ___Heat ___Other

___Leg elevation ___Massage _____

Have you had previous vein treatment?

By whom? _____ When? _____

- If so, which of the following methods was used:

___Cosmetic Injections ___Laser catheter ablation ___Other

___Radiofrequency closure ___Vein stripping ___Unknown

Patient Name: _____ Date:_____

Signature: _____