



**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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Congestive Heart Failure      | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Lupus               |
| <input type="checkbox"/> COPD                          | <input type="checkbox"/> History of DVT      | <input type="checkbox"/> Hepatitis B         |
| <input type="checkbox"/> Kidney Disease                | <input type="checkbox"/> History of PE       | <input type="checkbox"/> Hepatitis C         |
| <input type="checkbox"/> Renal Failure/ Dialysis       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Bleeding or Clotting Disorder | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> HIV or AIDS                   | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Stroke              | _____  |

**Current Symptoms:** Please mark all that apply

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Blurred/Loss of Vision | <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Abdominal Pain      |
| <input type="checkbox"/> Dizziness/Vertigo      | <input type="checkbox"/> Palpations  | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Seizures               | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Allergies   | _____  |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> 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?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Red/purple spider veins | <input type="checkbox"/> Bulging veins             | <input type="checkbox"/> Calf/thigh/buttock pain |
| <input type="checkbox"/> Skin discoloration      | <input type="checkbox"/> Venous ulcers/open wounds | <input type="checkbox"/> Black toe/Gangrene      |
| <input type="checkbox"/> Leg pain                | <input type="checkbox"/> Cramping                  | <input type="checkbox"/> Itching                 |
| <input type="checkbox"/> Swelling                | <input type="checkbox"/> Burning                   | <input type="checkbox"/> Heaviness               |
| <input type="checkbox"/> Bleeding from veins     | <input type="checkbox"/> 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: \_\_\_\_\_

