

DALLAS VEIN SPECIALISTS

LONNIE L. WHIDDON, M.D.

PATIENT INFORMATION

Patient Name:		Age:	Date of Birth: ____/____/____	Sex: M F	SSN: ____-____-____
Address:				City:	State:
Zip:	E-Mail:				
Home #:	Work #:	Cell #:	Other:		
Employer Name:		Occupation/Title:		Phone #:	
Employer Address:			City:	State:	Zip:

SPOUSE INFORMATION (FOR INSURANCE PURPOSES)

Name:	Date of Birth: ____/____/____	SSN: ____-____-____	Cell #:
Employer Name:		Phone #:	

REFERRING PHYSICIAN (OR SOURCE) INFORMATION

Name:	Specialty:		
Address:	City:	State:	Zip:
Other Referring Source:			

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone #:
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INSURANCE INFORMATION

Primary Insurance Company:
Secondary Insurance Company:

Authorization to Release Information: I hereby authorize Dallas Vein Specialists to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of the office visit and that fees collected on the days of procedures. If for any reason it becomes necessary to initiate collections proceedings, I understand that I am responsible for the cost off all treatments received, as well as any and all legal or collection fees Dallas Vein Specialists incurs. **I agree to inform DVS of any changes in my insurance policy.**

Sign: _____

Date: ____/____/____

HEALTH INFORMATION

Patient Name:	Height:	Weight:
Primary Care Physician:	Phone #:	
Chief Complaint:		

YOUR CURRENT LEG SYMPTOMS

Please circle all that apply.			Describe how long these symptoms have been present.	Please circle all that apply.			Describe how long these symptoms have been present.
Ache/Hurt:	Left	Right		Skin Discoloration	Left	Right	
Swell:	Left	Right		Purple/Red Veins	Left	Right	
Cramp:	Left	Right		Vein Network	Left	Right	
Restlessness:	Left	Right		Flat, Blue/Green Veins	Left	Right	
Fatigue:	Left	Right		Bulging Veins	Left	Right	
Itch:	Left	Right		Ruptured Vein / Bleeding	Left	Right	
Other:	Left	Right		Abdominal Veins	Left	Right	

CONSERVATIVE THERAPY

Please check any methods you may have used to relieve your symptoms.			
No Discomfort		Warm Soaks	
Leg Elevation		Cold Packs	
Exercise		Pain Meds	
Flexion / Extension		Aspirin	
Walking		Tylenol	
Support Hose (please note amount of time worn) # Months/Years/Days		Ibuprofen	
Wraps		Other:	

Are you here for prominent veins around the eyes? Yes No

PAST MEDICAL HISTORY

Have you had any previous vein treatment? Please list the treatment and the doctor.

Are you currently being treated for an illness: If so please explain.

Please list any operations or procedures you have previously had and when these have occurred.

Are you pregnant or could you possibly be pregnant?

DO YOU HAVE A HISTORY OF THE FOLLOWING?

Check those that apply		When were you diagnosed?
Migraine Headaches		
Diabetes (list type)		
Anemia		
Bleeding Disorder		
Clotting Disorder		
DVT (Deep Vein Thrombosis)		
Heart Disease		
Hypertension		
Superficial Thrombophlebitis		
Leg Ulcers		
Trauma to the leg		
Hepatitis (list type)		
HIV		
Other:		

Do you smoke?	Yes	No	How often:
Do you drink?	Yes	No	How often:

FAMILY HISTORY

Do you have a family history of:

Check those that apply		Relationship and Treatment (if known)
Varicose veins		
Spider Veins		
Venous Ulcers		
Clotting Disorders		
Bleeding Disorders		
Stroke		

MEDICATIONS

Please list any medications with doses do you have been prescribed or over the counter medications you take regularly.

Do you have any sensitivity or allergies to medicines or tape? List all:
