Patient Name (First Middle Last) _____

Date of Birth_____Social Security # _____

Address _____

City_____State_____Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Other Phone _____

Email_____Place of Birth _____

Occupation_____Retired Yes No

Gender Male Female Status Single Married Divorced Widowed

Height _____ Weight _____ EXERCISE Yes No Times per Week _____

Emergency Contact Name _____

Relationship_____Phone Number _____

Referring Doctor_____Last Visit _____

Primary Care Doctor_____Last Visit _____

Cardiologist_____Last Visit _____

Other Doctor_____Last Visit _____

Pharmacy_____Phone_____Location _____

How did you hear about us _____

Reason for today's visit _____

CURRENT / RECENT SYMPTOMS **Check all that apply**

	YES		YES		YES
Fever		Chest pain		Coldness in Feet / Toes	
Fatigue		Palpitations		Swelling in Legs / Feet	
Weakness		Leg pain with walking		Skin discoloration in Legs/Feet	
Weight Gain Loss		Shortness of Breath		Muscle weakness	
Night Sweats		Cough		Numbness in Feet / Toes	
Loss of Appetite		Abdominal Pain		Tingling in Feet / Toes	
Insomnia		Blood in stools		Seizures	
Double Vision		Nausea / Vomiting		Tremors	
Blurred Vision		Urination: Painful / Frequent		Speech Difficulty	
Headache		Blood in Urine		Lack / Loss of Balance	
Hearing Loss		Joint Pain		Restless Legs	
Ringing in Ears		Pain in Legs		Anxiety	
Uncontrolled Nose Bleeds		Chronic dry skin / Itching		Depression	
Dizziness / Vertigo		Unhealed Sores / Ulcers		Suicidal Thoughts	
Bleeding Gums		Rash			
Difficulty Swallowing		Hair loss on lower leg			
Runny / Congested Nose		Muscle cramps			
Other:					

Women Only: CURRENT / RECENT SYMPTOMS

	YES
Heavy Menstrual Cycles	
Pelvic Pain	
Pelvic Fullness / Bloating	
Pain with Intercourse	
Labial Varicose Veins	
Vulvar Varicose Veins	
Multiple Miscarriages	
Infertility	
Number of Pregnancies _____	

MEDICAL HISTORY **Check all that apply**

	YES		YES		YES
Abdominal Aortic Aneurysm		Epilepsy		Peripheral Arterial Disease	
Atrial Fibrillation		Fibromyalgia		Psoriasis	
Allergies / Sinus		GERD (acid reflux)		Rheumatoid Arthritis	
Alzheimer's Disease		Glaucoma		Scleroderma	
Anemia		Gout		Sleep Apnea	
Arthritis		Heart Attack		Stroke	
Asthma		High Blood Pressure		Seizures	
BPH (Benign Prostatic Hyperplasia)		High Cholesterol		Thyroid Disease Hypo Hyper	
Bleeding Disorder		HIV /AIDS		TIA	
Cancer Type:		Kidney Disease / Dialysis		Tuberculosis	
Carpal Tunnel Syndrome		Low Blood Pressure		Ulcers	
Cataracts		Liver Disease		Varicose Veins	
Clotting Disorder		Lupus		Venous Insufficiency	
Congestive Heart Failure		Lung Disease COPD		Uterine Fibroids	
Coronary Artery Disease		Migraines		Chronic Pelvic Pain / Congestion	
Dementia		Multiple Sclerosis			
Depression		Neuropathy			
Detached Retina		Osteoarthritis			
Diabetes Insulin Meds Diet		Osteoporosis / Osteopenia			
Emphysema		Parkinson's Disease			

SURGICAL HISTORY Check all that apply and indicate year

Abdominal Aortic Aneurysm		Carotid Endartectomy (CEA)		Kidney Removed Right / Left	
Angiogram		Carpal Tunnel		Leg Amputation Right / Left	
Angioplasty / Stent		Coronary Artery Bypass		Pacemaker / Defibrillator	
Appendectomy		Colon		Prostate	
Back		Fistula			
Bladder		Gall Bladder			
Bowel		Heart Bypass (CABG)			
Breast		Heart Valve Replacement			
Bypass Legs		Hysterectomy			
Cardiac Angioplasty / Stent		Joint Replacement			

Allergies

Allergy	Reaction

Medications

Medication	Strength (mg)	Frequency

Social History

Tobacco	Never Rarely Daily Previous	Packs per Day	Length of Use	Quit
Alcohol	Never Rarely Daily Previous	Amount	Length of Use	Quit
Illicit Drugs	Never Rarely Daily Previous	Type	Length of Use	Quit

Family History

	Living	Deceased	Health Issues	Age	Cause of Death
Mother					
Father					
Sibling					
Sibling					
Children					
Children					
Spouse					
Other					

Release and Authorization

I authorize the doctor and his staff to release any information including the diagnosis and records of treatment or examination to third party payers and/or other health care practitioners. I give consent for other health practitioners and medical facilities to release medical records to Desert Vein and Vascular Institute / Dr. Parag Rami as it relates to my continuing care. I understand that this consent is good for one year from the date signed and maybe revoked at any time in writing.

I authorize and request my insurance company to pay directly to Desert Vein and Vascular Institute / Dr. Parag Rami and its affiliates any benefits covered by my insurance plan.

I understand that my insurance may pay less than the actual bill for service. I agree that I am responsible for any charges for services rendered to myself or my dependent(s).

[ ]***Yes*** [ ]***No*** I consent to have detailed messages and test results left on an answering machine, voice mail, or email.

Patient PRINT _____

Signature_____Date _____

Legal Representative (if applicable) Signature_____Date _____

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