LUMIERE COSMETIC VEIN CENTER, P.A.

.

Patient Information

Name (First) _____ (MI) _____ (Last) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____ DOB ___/___/___ Social Security _____

Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W

Occupation _____ Employer _____

Work Phone _____ City _____ State _____

Insurance Information: ☐ Patient ☐ Spouse (If neither patient or spouse policy holder DOB ___/___/___)

Primary _____ Group _____ ID # _____ Insured's Name _____

Secondary _____ Group _____ ID # _____ Insured's Name _____

Spouse Information:

Name _____ DOB ___/___/___ Social Security _____

Occupation _____ Employer _____

Work Phone _____ City _____ State _____

How did you find out about us?

☐ Referral from Physician _____ (Name) ☐ Friend/Family Member _____ (Name)

☐ Radio _____ (Station) ☐ TV _____ (Station) ☐ Internet _____ (Website) ☐ Other _____ (List)

Physician That Referred You

Name _____ Specialty _____ Phone _____

Address _____ City _____ State ____ Zip _____

Primary Care Physician (if other than referring physician)

Name _____ Specialty _____ Phone _____

Address _____ City _____ State ____ Zip _____

OB/GYN Physician (if other than referring physician)

Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

In Case of Emergency, Contact _____ **Phone** _____

I authorize Lumiere Cosmetic Vein Center, P.A. to execute any documents necessary, and release to my health insurance carrier, or other organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at Lumiere Cosmetic Vein Center, P.A.

Signature _____ Date _____

Name: _____
Date: _____Date of Birth: _____ Age: ____

LUMIERE COSMETIC
VEIN CENTER, P.A

Patient History

Symptoms: ***(Please check if yes)***

	R	L
Aching / pain in legs	☐	☐
Heaviness	☐	☐
Tiredness / fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your symptoms worse with or after activity? ☐
Do your symptoms keep you from doing anything? ☐

Check if you've had any of the following:

Heart disease ☐
Peripheral arterial disease ☐
HIV ☐
Hepatitis ☐
High blood pressure ☐
Diabetes ☐
Cancer ☐
Leg trauma / surgery ☐
Asthma/COPD ☐
Major surgery / hospitalizations: ☐

_____
_____
_____

Do you have an Advanced Directive? ☐Yes

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

☐ Was diagnosed with PAD in past
☐ Have/had cramping leg pain that worsens with walking, forcing me to stop walking
☐ Feet/toes become pale and painful with exercise or when elevating them
☐ Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

☐ Pain medications ☐ Weight loss ☐ Leg elevation ☐ Job change
☐ Exercise ☐ Compression stockings or leg wraps? Strength of stockings: _____ mmHg

***Please list your* weight:** _____ lbs and **height:** ____ft ____in

Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling? ☐
Do(es) your leg(s) feel better when moving it (them) or walking? ☐
Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? ☐
Are your leg symptoms worse later in the day or night? ☐

Please check below if you have, or have had, any of the following:

☐ A prior evaluation for your veins: _____*(yr)*
☐ Previous vein surgery or laser treatments: _____*(yr)*____*R*____*L*
☐ Previous vein injections: _____*(yr)*____*R*____*L*
☐ Bleeding from a vein: _____*(yr)*____*R*____*L*
☐ A leg ulceration: _____*(yr)*____*R*____*L*
☐ Superficial thrombophlebitis or an inflammation of a vein: _____*(yr)*____*R*____*L*_____ *(Location)*
☐ Any type of blood clot: _____*(yr)*____*R*____*L*_____ *(Location)*
☐ Any type of clotting disorder: _____ *(Diagnosis)*
☐ Migraines with aura
☐ Diagnosed with a PFO (patent foramen ovale)

☐ A family history of vein disease
☐ A family history of leg ulceration
☐ A family history of blood clots
☐ A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? ☐
Are you breast-feeding? ☐ Are your legs more painful associated with menstruation? ☐
Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? ☐
Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's ages:_____

Provider reviewed with patient:_____ Date: _____

LUMIERE COSMETIC VEIN CENTER, P.A.

Today's Date: _____Your Appointment Time: _____ a.m. / p.m. Clinic Location: _____

Patient Name:		**Date of Birth:**
What is your "Reminder Preference" for communication for you? SELECT BEST ONE BELOW: ☐ Home Phone: ☐May leave voice mail ☐Text ☐ Work Phone: ☐May leave voice mail ☐Text ☐ Cell Phone: ☐May leave voice mail ☐Text ☐ Email:	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to State	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State
Preferred Primary Language ☐English ☐Other:		

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?
Date of Last Flu Shot ____/____ (Month/Year) ☐ No/Refused ☐Decline for Medical Reason → ☐ Allergy ☐ Other Medical Reason

Social History:

Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on _____(approx. date)
☐ Current Smoker → Started _____(approx. date) Amount of cigarettes: _____ per day
☐ Use tobacco in other forms → _____ Amount: _____per day

Alcohol Use History: Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES
If Yes: → How often? ☐ monthly or less ____ drinks per month ____ drinks per week ____ drinks per day
How often >6 drinks on one occasion in past year? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐Daily

Allergies and Your Allergic Response: or ☐ *No Known Allergies*

_____ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

☐ *None*

#	Medication Name	Dose	Frequency	Route
1				☐Oral ☐
2				☐Oral ☐
3				☐Oral ☐
4				☐Oral ☐
5				☐Oral ☐
6				☐Oral ☐
7				☐Oral ☐
8				☐Oral ☐

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Blood Pressure: _____ / _____ R L **MRN: _____**

Staff Signature: _____ Date: _____

Patient Education from Healthwise: ☐*Tobacco Cessation <24 months* ☐*Hypertension >140/90* or *pre-hypertension 120/80 to 139/89*

Physician Signature: _____ Date:_____

Diagnosis Code(s) from Encounter Form: (1) Primary: _____Others:_____