New Patient Intake Form

PREMIER VEIN CENTER

Name: _____ Date of Birth _____ Today's Date: _____
Address: _____ Phones: Home _____ Work: _____ Cell: _____
Occupation: _____ Employer: _____

Email: _____ Emergency Contact-name and phone number: _____

_____

Medical History (check those that apply)

	High blood pressure		Diabetes		High cholesterol		Heart disease
	Blood clot (legs)		Blood clot (lungs)		Heart murmur		Stroke
	Cancer		Poor wound healing		Bleeding disorder		Anesthesia complications
	Venous ulcers		Recurrent miscarriages		Artificial joints		Anxiety/depression

Other (please describe below):

_____

Past Surgical History
Have you ever seen/been treated by a vascular surgeon: Yes No
If yes, please describe:

_____

Other surgical history:

_____
_____
_____

Total Pregnancies_____ Deliveries_____

Medications and dosages: (include vitamins and over the counter products)

_____ _____ _____
_____ _____ _____
_____ _____

Allergies: _____ Latex allergy? Yes No

Social History
Smoker: Yes No (If yes, packs per day since what age) _____
Alcohol: Yes No (If yes, number per week) _____
Exercise: Yes No (If yes, how much / how often) _____
Illicit drug use: Yes No

Family Medical History (check all that apply)

	High blood pressure		Diabetes		High cholesterol		Heart disease
	Blood clot (legs)		Blood clot (lungs)		Heart murmur		Stroke
	Cancer		Lung problems		Bleeding disorder		Seizures
	Venous disease		Liver disease		Anesthesia complications		Anxiety/depression

Primary care doctor:

_____