Varicose Vein Questionnaire

Please answer the following questions. Elaborate where necessary.

Name: ______________________________ DOB: ________________________

Age: ________________ Sex: Male/Female

Who is your Primary Care Physician? ____

1. Do you experience any of the following sensations in your legs? Circle all that apply.

Aching	Pain
Heaviness	Tiredness
Fatigue	Itching
Burning	Swelling
Cramping	Restless Legs
Throbbing	

   Other: ____

2. When did you first notice vein related discomfort? ____________________________

3. How does your leg pain affect daily activities? ______________________________

4. Have your veins worsened in recent months? Yes No

5. Does elevating your legs relieve the discomfort? Yes No

6. Do you wear support/compression hose prescribed by a doctor? Yes No
   If yes, for how long? ________________ Do they provide relief? Yes No

7. Have you ever had bleeding for your leg veins? Yes No

8. Do you have any problem walking? Yes No

9. Have you ever had your veins evaluated? Yes No
   If so, when and where? ____

10. Have you ever had any tests done on your veins? Yes No

11. Have you ever had vein stripping or phlebectomy surgery? Yes No
    If yes, when, where and which leg? _______________________________________

12. Have you ever had sclerotherapy vein injections? Yes No
    If yes, when, where, and which leg? ______________________________________

13. Have you ever had a blood clot? Yes No

14. Have you ever had phlebitis? Yes No
    If yes, when and which leg? ____

15. Have you have had a venous stasis ulcer? Yes No

Past Medical History

1. Have you ever been hospitalized?
   Yes **No**
   If yes, for what reason and when?
   ____
   ____

2. Have you ever had surgery?
   Yes **No**
   If yes, what type of surgery and when?
   ____
   ____

3. Do you have heart disease/coronary artery disease?
   Yes **No**
4. Do you have lung disease/emphysema?
   Yes **No**
5. Do you have high blood pressure/ hypertension?
   Yes **No**
6. Do you have hepatitis?
   Yes **No**
7. Do you have arthritis?
   Yes **No**

Pregnancy History

1. Do you think that you are presently pregnant?
   Yes **No**
2. How many times have you been pregnant?
   ____
3. Do you intend to have any more children?
   Yes **No**
4. Are you presently breastfeeding?
   Yes **No**

Social History

1. What is your occupation?
   ____
   ____
2. Do your varicose veins make work difficult?
   Yes **No**
3. Do you smoke?
   Yes **No**
   If yes, how many packs per day?
   ____

Medications

1. Do you take any blood-thinning medication, such as:
   Coumadin, Warfarin, Pradaxa, Aspirin, Plavix, Ticlodipine, Trental, Effient, Brilinta or Pentoxifylline?
   Yes **No**

2. Are you taking hormones or birth control pills?
   Yes **No**

3. Please list all prescription, over-the-counter, vitamins, and herbal medications that you are currently taking. Please include dosage.
   ____
   ____
   ____
   ____
   ____
   ____

Allergies

1. Do you have any drug allergies? List them and describe your reactions (rash, hives, shortness of breath, etc.).
   ____
   ____
   ____
   ____
   ____

2. Are you allergic to any form of Iodine or X-Ray contrast?
   Yes **No**

Family History

Does anyone in your family have varicose veins, spider veins, or leg ulcers? Please circle all that apply:

Mother **Father**
Sister(s) **Brother(s)**
Children

Southern Vascular Institute
PATIENT INFORMATION

PATIENT INFORMATION (PLEASE PRINT)			**Social Security #**			
Last Name	First Name & MI	Name Called By:	Marital Status M S W D Sep	Date of Birth	Age	Sex M F

Street Address	City and State	Zip Code	Patient Home #
Patient's Employer	Occupation __Retired __Student		Patient Cell #
Employer's Street Address	City and State	Zip Code	Patient Work #

In Case of Emergency	Emergency Contact #	Patient E-Mail Address:
Referred By:	Primary Care Physician	Other Family Members Seen in Office

PERSON RESPONSIBLE FOR PAYMENT (If different from above.)

Last Name	First Name & MI	Relationship to Patient __Self __ Spouse __Father __Mother __Other

Street Address	City and State	Zip Code	Home #
Employer			Cell #
Employer's Street Address	City and State	Zip Code	Work #

COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT

Contact Name	Relationship to Patient: __Father/Stepfather __Mother/Stepmother __Guardian		Home #
Street Address	City and State	Zip Code	Cell #

I understand that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a co-payment, deductible, co-insurance or payment in full by the following method ___ Cash ___ Check ___ Visa/MC ___ Discover ___ Patient Initials

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Southern Vascular Institute. I realize I am responsible for non-covered services. ___ Patient Initials

INFORMATION RELEASE: I authorize Southern Vascular Institute to release to my insurance carriers or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____ Patient Initials

ACKNOWLEDGEMENT: I acknowledge all information above is accurate.

Signature of Patient or Legal Guardian, if a minor	Date

Southern Vascular Institute
Authorization of Use and Disclosure of Protected Health Information
(Page 1 of 2)

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we will leave a message stating our practice name, telephone number, and contact on the answer machine at your residence. Information will not be left with an unauthorized person. If you would like to have information released to someone other than yourself, please complete the following:

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Our practice will notify you of an upcoming appointment by telephone.

I ____, hereby authorize Southern Vascular Institute and staff to leave appointment reminders and medical information pertaining to my care at the following telephone numbers and I will assume responsibility to notify the practice whenever this information changes.

Home Telephone ______________________________________

Work Telephone ______________________________________

Cell Phone ______________________________________

If you have an answering machine, may we leave messages regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Southern Vascular Institute?

Yes ______ No _____ (Southern Vascular Institute will leave a message only when the answer machine identifies the patient/household by name).

If "No" how else may we contact you regarding this information? ____

Please list any other restrictions regarding messages or reminders about your healthcare: ______________________________

____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "notice of Privacy Policies and Practices" brochure and/or consent will require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restriction on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:_________________________

____

____

Southern Vascular Institute
Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Print Name	Contact Phone #
______________________________ (Name of person / relation / organization	______________________
______________________________ (Name of person / relation / organization	______________________
______________________________ (Name of person / relation / organization	______________________

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided by Southern Vascular Institute.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify"

____

Expiration Date of Authorization: This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Southern Vascular Institute. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure: The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Acknowledgement: Please sign below, acknowledging you have been offered an opportunity to review our Notice of Privacy Practices:

____
Name of Patient (Print or Type)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

If you choose not to sign this acknowledgement form, please check the box, sign and date. ☐

____
Signature of Patient Date

DIRECTIONS TO OUR OFFICE

DIRECTIONS FROM SPARTANBURG

Take I-85 South to Exit 56-57 (highway 14, the GSP airport exit). At the top of the exit, turn left. You will drive back over the over pass of the interstate. At the second light you come to turn left off of SC-14 going towards the hospital. Look for the hospital sign that is blue with white writing that says Medical office building directly on your right. Then take your immediate right onto a road that intersects the hospital the medical office building. Turn your immediate right again into the medical office building (Entrance B). There are water fountains and flag poles out front of the medical office building. Come through the double doors and take the elevators to the second floor. Our suite is 2400 on the left at the end of the hallway.

DIRECTIONS FROM GREENVILLE, ANDERSON, SENECA

Take I-85 North to Exit 56-57 (Highway 14, the GSP airport exit). At the top of the exit turn right. At the first light you come to turn left off of SC-14 going towards the hospital. Look for the hospital sign that is blue with white writing that says Medical office building directly on your right. Then take your immediate right onto a road that intersects the hospital the medical office building. Turn your immediate right again into the medical office building (Entrance B). There are water fountains and flag poles out front of the medical office building. Come through the double doors and take the elevators to the second floor. Our suite is 2400 on the left at the end of the hallway.

SOUTHERN VASCULAR INSTITUTE

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