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LASER AND VEIN ESTHETICS

DATE _____

NAME _____ SEX: M _____ F _____ BIRTHDATE _____

CURRENT CONDITION RELATED TO TODAY'S APPOINTMENT:

ASSOCIATED SYMPTOMS: _____

WHAT MEDICAL PROBLEMS HAVE YOU HAD IN THE PAST, OTHER THAN WHAT YOU ARE SEEING THE DOCTOR TODAY?
THESE MAY BE ACTIVE OR NOT BOTHERING YOU NOW; SOME EXAMPLES: CANCER, COLON PROBLEMS, PNEUMONIA,
BRONCHITIS, DEPRESSION, MIGRAINES, etc. _____

PAST SURGICAL HISTORY: _____

NAME OF PHYSICIAN WHO REFERRED YOU _____

HAVE YOU EVER HAD OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?
(PLEASE CHECK IF YES)

HIGH BLOOD PRESSURE _____

HEPATITIS _____

DIABETES _____

ULCER DISEASE _____

HEART PROBLEMS _____

VASCULAR DISEASE _____

CANCER _____

BLOOD CLOTS _____

HIV _____

ARE YOU TAKING ANY MEDICATIONS NOW? YES _____ NO _____ IF YES, PLEASE LIST THEM

DO YOU HAVE ANY ALLERGIES TO MEDICINES? YES _____ NO _____ IF YES, PLEASE LIST THEM:

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL AND FAMILY HISTORY:

DO YOU SMOKE? YES _____ NO _____ HOW MANY PACKS A DAY? _____

DO YOU DRINK? YES _____ NO _____ HOW MUCH OR HOW FREQUENT? _____

HAS ANYONE IN YOUR FAMILY (MOTHER, FATHER, BROTHERS, SISTERS, GRANDMOTHERS, GRANDFATHERS)
EVER HAD ANY OF THE FOLLOWING CONDITIONS? PUT A CHECK NEXT TO EACH.

HIGH BLOOD PRESSURE _____

VARICOSE VEINS _____

DIABETES _____

CANCER _____

HEART PROBLEMS _____

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Name: _____

Please circle all that apply:

Do you take any of the following on a regular basis?

Oral contraceptives Premarin Aspirin Steroids Digoxin

2. Are you allergic to: Iodine Local anesthetics (Xylocaine) Tape

3. Do you have a family history of varicose veins or spider veins? Yes No

If yes, please list the relatives who have them: _____

How many years have you had varicose or spider veins? _____

Did you first notice these veins: after an accident/trauma before pregnancy

After or during pregnancy after taking hormones or oral contraceptives

Are you required to be on your feet for long periods of time? Yes No

Are you developing new veins? YES NO

Do you bruise easily? Yes No

Have you had any previous bypass surgery? Yes No

4. Do you have: excessive bleeding bleeding disorder dizziness

transient vision loss transient weakness of limbs

1. Do you now have or have you had: unsightly veins right left

Aches or pains right left

Heaviness or tired legs right left

Ankle edema or swelling right left

Itching right left

Night cramps right left

Bleeding from veins right left

Discoloration of legs right left

Dermatitis (eczema) right left

Ulceration right left

2. Do you have a previous history of: Superficial phlebitis right left

Deep thrombophlebitis right left

Pulmonary emboli right left

3. Have you had treatments of: Compression stockings right left

Length of time worn _____

Compression grade (mmHg) 15-20 20-30

30-40 40-50

Ligation right left

Vein stripping right left

Local excision right left

Cautery right left

Sclerotherapy right left

4. Do you have leg pains while walking in the: foot right left

Calf right left

Thigh right left

Buttock right left

5. Do you have leg pains while resting in the: foot right left

Calf right left

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PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security: _____

Effective April 14, 2003, the federal government set a law in place to protect you and the release of your medical information whether it be in written or oral form. Our office is permitted by law not to release protected health information outside of treatment, payment, and healthcare operations without your written consent.

Please list the people (including family members) or companies in which you wish the office of David Vanderpool, M.D. to release your medical records.

_____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates of treatment: _____

All Healthcare information

I hereby authorize the office of David Vanderpool M.D. to release my protected health information to the above people listed. I understand I have the right to revoke this consent at anytime in writing. I am also aware that this consent is binding and will expire two years from the date of signature.

Patient's signature

Date of Signature

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PATIENT INFORMATION

Today's Date _____/_____/_____

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address _____

Home phone: _____ Work phone: _____ Cell phone: _____

Date of Birth _____/_____/_____ Social Security: _____/_____/_____

Marital Status: Married Single Divorced Widowed

How did you hear about us? _____

My Insurance is Covered Through: Employer Self Spouse Other

IF YOUR INSURANCE COVERAGE IS UNDER ANOTHER PERSON'S PLAN, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____

Date of Birth: _____/_____/_____ Social Security _____/_____/_____

INSURANCE AUTHORIZATION:

I hereby authorize my insurance benefits to be paid directly to David Vanderpool, M.D. I realize I am responsible for any fees not covered by my insurance policies. I also authorize the release of pertinent medical information to my insurance carriers.

Patient Signature _____ Date: _____

Patient Rights

Effective April 14, 2003: The Federal Government set a law in place to protect you and the release of your medical information. We, at Dr. Vanderpool's Office, promise to do our part in upholding this law. Our office is permitted by federal laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

A Copy of the Federal Privacy Law is available to you at your request

Yes, I would like a copy of the Federal Privacy Law No, I would not like a copy of the Federal Privacy Law
I have read about information regarding the Federal Privacy Law and understand my rights as a patient at this office.

Patient Signature: _____ Date: _____