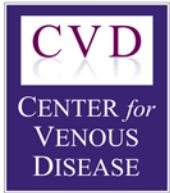


**Patient Intake Form**



**Welcome NEW CVD PATIENTS! Please answer all questions.**

MR# \_\_\_\_\_ NP# \_\_\_\_\_ DOB \_\_\_\_\_  
 Form reviewed by: \_\_\_\_\_ CVD Staff

**OFFICE USE ONLY:**  
 DL and Insurance card scanned and verified  
 Benefits Verified  
 Privacy Policy Signed  
 Financial Policy Signed  
 This form scanned to eDocs  
 YES \_\_\_\_\_ DATE \_\_\_\_\_ INT. \_\_\_\_\_

**Patient Intake Form- Our ability to treat you, and have your insurance company pay for our services is directly related to accurate documentation. You are ultimately responsible for payment for all services rendered. All co-pay, co-insurance, and unmet deductibles will be collected prior at time of service.**

**PATIENT INFORMATION**

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ INT \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Referred by: \_\_\_\_\_ PAIN SCORE 1(mild) – 10(severe) \_\_\_\_\_

Front desk to verify completion of form and enter history in EMR.

**Family History - General History (Check all that apply)**

- Alzheimer's
- Anemia
- Anxiety
- Cancer \_\_\_\_\_?
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- Diabetes
- Heart Disease \_\_\_\_\_?
- Hypertension
- Hypothyroidism
- Kidney Disease
- Liver Disease
- Lung Disease \_\_\_\_\_?
- Multiple Births \_\_\_\_\_?
- Phlebitis
- Seizures
- Stroke
- Thyroid Disease
- Other \_\_\_\_\_

**Social History**

- Occupation \_\_\_\_\_
- Marital Status \_\_\_\_\_
- Religious Preference \_\_\_\_\_
- Alcohol Consumed \_\_\_\_\_
- Tobacco Use: Current \_\_\_\_\_ Quit \_\_\_\_\_ Date \_\_\_\_\_
- Drug Use \_\_\_\_\_
- Hobbies \_\_\_\_\_

**Surgical History**

Procedure(s) \_\_\_\_\_  
 Date(s) \_\_\_\_\_

**Allergies – (EMR-Med/Allergies)**

Date \_\_\_\_\_  
 Medication \_\_\_\_\_  
 \*Reaction \_\_\_\_\_  
 Other: \_\_\_\_\_

**Patient Intake Form**

**Medications – (EMR-Med/Allergies)**

Start Date _____	_____	_____
Medication _____	_____	_____
Strength _____	_____	_____
Dr./Rx _____	_____	_____

Start Date _____	_____	_____
Medication _____	_____	_____
Strength _____	_____	_____
Dr./Rx _____	_____	_____

**Chief Compliant – (EMR-Encounter) \_\_\_\_\_**

**HPI - History of Present Illness RELATED TO VEIN(S)**

Lower Extremity Leg Pain or Discomfort:

-Onset

- |                                   |                                 |
|-----------------------------------|---------------------------------|
| <input type="radio"/> 1-3 months  | <input type="radio"/> > 1 year  |
| <input type="radio"/> 4-6 months  | <input type="radio"/> > 2 years |
| <input type="radio"/> 6-12 months | <input type="radio"/> > 3 years |

-Frequency

- |  |   |
|--|---|
| <input type="radio"/> Daily                  | <input type="radio"/> Several times per month   |
| <input type="radio"/> A few times per week   | <input type="radio"/> With increasing frequency |
| <input type="radio"/> About once a week      | <input type="radio"/> With decreasing frequency |
| <input type="radio"/> About every other week | <input type="radio"/> Ongoing                   |

-Timing

- |   |                                       |
|---|---------------------------------------|
| <input type="radio"/> Mostly during the day | <input type="radio"/> Mostly at night |
| <input type="radio"/> Mostly in the evening |                                       |

-Severity

- |                                 |  |
|---------------------------------|--|
| <input type="radio"/> Mild      | <input type="radio"/> Stable                 |
| <input type="radio"/> Moderate  | <input type="radio"/> Improving              |
| <input type="radio"/> Severe    | <input type="radio"/> Fluctuates in severity |
| <input type="radio"/> Worsening |  |

-Location

- |                                  |                                   |
|----------------------------------|-----------------------------------|
| <input type="radio"/> Left thigh | <input type="radio"/> Right thigh |
| <input type="radio"/> Left knee  | <input type="radio"/> Right knee  |
| <input type="radio"/> Left calf  | <input type="radio"/> Right calf  |
| <input type="radio"/> Left ankle | <input type="radio"/> Right ankle |

-Quality/Description

- |  |                                |
|--|--------------------------------|
| <input type="radio"/> Pain or discomfort             | <input type="radio"/> Swelling |
| <input type="radio"/> Ants crawling/pins and needles | <input type="radio"/> Cramping |
| <input type="radio"/> Burning or itching             | <input type="radio"/> Aching   |
| <input type="radio"/> Shock-like                     |                                |

-Exacerbating Factors

- |   |  |
|---|--|
| <input type="radio"/> Painful leg movements | <input type="radio"/> Skin breakdown                                     |
| <input type="radio"/> Interrupted sleep     | <input type="radio"/> Swelling limits movement without pain              |
| <input type="radio"/> Fatigue               | <input type="radio"/> Pain limits mobility or limits standing or sitting |

-Remitting Factors

- |   |   |
|---|---|
| <input type="radio"/> Wearing compression wraps or stockings                | <input type="radio"/> warm or cold compress |
| <input type="radio"/> Taking over-the-counter anti-inflammatory medications | <input type="radio"/> elevation of legs     |

**Patient Intake Form**

- Rubbing the legs/massage
- other \_\_\_\_\_

Previous Vein Treatments

-Patient Prior Vein Treatments

- Sclerotherapy
- Vein stripping/ligation
- Vein ablation
- Phlebectomy
- Surface laser (skin)

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Quality of Life

- The symptoms affect and/or limits quality of life
- The symptoms affect performance on the job and/or limits advancement
- Condition affects patient sleeping through the night
- Condition limits patients choices when getting dressed for work, recreation, or social activities
- Condition is embarrassing for patient

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Symptoms (Check all that apply)**

-ROS – Constitutional

- Unremarkable (Normal)
- Headache
- Fever
- Weight loss
- Weight gain
- Fatigue
- Increased appetite
- Decreased appetite

-Musculoskeletal

- Unremarkable (Normal)
- Joint pain
- Joint stiffness
- Joint swelling
- Muscle Pain
- Muscle weakness
- Back pain
- Neck Pain

-Skin

- Unremarkable (Normal)
- Rash
- Skin changes
- Dry skin
- Pigmentation
- Moles

-Neurological

- Unremarkable (Normal)
- Headaches
- Dizziness
- Syncope
- Vertigo
- Seizures
- Numbness
- Tingling
- Weakness
- Difficulty walking
- Memory disturbance
- Speech changes
- Tremor

-ROS – Cardiovascular

- Unremarkable (Normal)
- Chest pain/pressure
- Palpitations
- Dyspnea
- Syncope
- Edema
- Leg cramps/calf pain

***Patient Intake Form***

**-Respiratory**

- Unremarkable (Normal)
- Cough
- Hemoptysis
- Pleuritic chest pain
- Wheezing
- Dyspnea

**-Gastrointestinal**

- Unremarkable (Normal)
- Frequent heartburn
- Abdominal pain
- Jaundice
- Blood in stool
- Black tarry stools
- Painful bowel movements
- Constipation
- Diarrhea

**-Hematology/Lymphatic**

- Unremarkable (Normal)
- Anemia
- Easy bruising/bleeding
- Lymphnode enlargement

**-Endocrine**

- Unremarkable (Normal)
- Polyuria
- Polydypsia
- Cold/heat intolerance
- Weight changes
- Difficulty or delayed healing

**-Psychological**

- Unremarkable
- Depression
- Anxiety
- Unusual stress