Lawrence P. Presant, D.O., PLLC
ARIZONA VEIN SPECIALISTS
Board Certified in Venous & Lymphatic Medicine

PATIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we will need you to complete the following questionnaire. All information obtained is strictly confidential.

PERSONAL HISTORY

Patient Name _____ Today's Date ____/____/_____
Date of Birth _____/_____/_____ Age _____ S.S. # _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____
Emergency Contact Name and Phone _____
How did you hear about us? _____

MEDICAL HISTORY

Do you have allergies? _____ List all allergies _____
_____

Are you currently taking any prescription drugs? ☐ Yes ☐ No Hormones? ☐ Yes ☐ No
If yes, please list them _____

Do you take any of the following? ☐ Aspirin ☐ Blood Thinners ☐ Vitamin E
If yes, for what? _____
Have you ever sued any physician at any time, for any reason? _____

Do you exercise? ☐ Yes ☐ No How often? _____ What kind? _____
Describe what kinds of fluids you drink daily and how much? _____

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

Are you breast feeding? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Have you ever had cosmetic surgery? ☐ Yes ☐ No If yes, where and when? _____

Have you had any recent surgery? ☐ Yes ☐ No If yes, for what? _____
Do you have any implants (e.g. pacemaker, pins in bones, etc…)? _____
Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ Herpes ☐ Arthritis ☐ Asthma ☐ HIV/AIDS ☐ Keloid Scarring

☐ Skin Disease / Lesions ☐ Seizure Disorder ☐ Hepatitis ☐Thyroid Imbalance ☐Neuromuscular Disease

☐ Any active infections ☐ Autoimmune Disease ☐ Blood Clotting Abnormalities ☐ Frequent Cold Sores

☐ Hormone Imbalance ☐ Other _____

I certify that the preceding medical and personal statements are true and correct. I am aware that it is my responsibility to inform the doctor of my current medical or health conditions and to update this history when necessary. A current medical history is essential for the doctor to deliver the appropriate treatment procedures. I understand that I am financially responsible for all charges at the time of service.

Signature: _____ Date: _____

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Name: _____ Date: _____ Age: _____ Height: _____ Weight: _____

When did you first notice your enlarged or discolored veins? _____

Which leg bothers you? ☐ Right ☐ Left ☐ Both

Symptoms are required for insurance coverage. Check all that apply, even if unsure.

☐ Sharp pain	☐ Burning	☐ Dull Pain	☐ Heaviness
☐ Aching legs	☐ Cramping	☐ Itching	☐ Throbbing
☐ Swelling	☐ Restless legs	☐ Tiredness	☐ Leg ulcers
☐ Appearance	☐ Dermatitis (rash) or bleeding		

Does this problem bother you in any way performing your normal daily activities? (resting or elevating legs). Required for insurance coverage. Please explain.

_____

_____

List medication being taken for pain (required: UnitedHealthCare) _____

_____

Have you ever had:

1. Phlebitis (inflammation, swelling) ☐ Yes ☐ No When? _____
2. Deep Vein Thrombosis (clot in leg) ☐ Yes ☐ No When? _____
3. Pulmonary Embolus (clot in lung) ☐ Yes ☐ No When? _____
4. Blood Thinner Medication ☐ Yes ☐ No When? _____
5. Leg or ankle ulcers / dermatitis ☐ Yes ☐ No When? _____
6. Painful varicose veins ☐ Yes ☐ No When? _____
7. Ultrasound or vein x-ray ☐ Yes ☐ No When? _____

Females:

Are you pregnant now? ☐ Yes ☐ No

Have you had any pregnancies? ☐ Yes ☐ No How many? _____

How many deliveries? _____

List any hormones you are taking _____

List all allergies _____

(Turn over to complete on back)

List all medications: _____
_____
_____

Have you ever smoked? ☐ Yes ☐ No ☐ Quit How much? _____
Do you drink alcoholic beverages? ☐ Yes ☐ No How much? _____
Do you have adverse reactions with scars? ☐ Yes ☐ No _____

Have you ever had any of the following?

AIDS or HIV positive?	☐ Yes ☐ No	Type _____	Dates _____
Hepatitis or jaundice?	☐ Yes ☐ No	Type _____	Dates _____
Cancer?	☐ Yes ☐ No	Type _____	Dates _____
Diabetes?	☐ Yes ☐ No	Type _____	Dates _____
Lupus or rheumatoid arthritis?	☐ Yes ☐ No	Type _____	Dates _____
Scleroderma?	☐ Yes ☐ No	Type _____	Dates _____
Hypertension?	☐ Yes ☐ No	Type _____	Dates _____
Heart disease or arrhythmia?	☐ Yes ☐ No	Type _____	Dates _____
Thyroid disease?	☐ Yes ☐ No	Type _____	Dates _____
Major injury / surgery in legs?	☐ Yes ☐ No	Type _____	Dates _____
Clotting or blood problems?	☐ Yes ☐ No	Type _____	Dates _____
Leg pain at night?	☐ Yes ☐ No	Type _____	Dates _____
Leg pain caused by standing?	☐ Yes ☐ No	Type _____	Dates _____
Leg pain caused by walking?	☐ Yes ☐ No	Type _____	Dates _____

Have you used medically supervised gradient support stockings? (Most insurance companies require a trial of 2 to 3 months to approve coverage for vein treatment.) ☐ Yes ☐ No
I obtained relief of symptoms. ☐ Yes ☐ No

I certify I have worn these stockings for _____ months.

Signed: _____

List family members with vein problems _____

Who may we thank for referring you to our office? _____