ATHENS VEIN & THORACIC SPECIALISTS

Date: _____/_____/_____

Vein History and Physical

Patient Name: _____ **DOB:** _____/_____/_____ **Age:** _____
Reason for Visit: _____
How did you hear about us? _____
Primary Care Physician: _____ **Referring Physician:** _____

Symptom(s):

___ Pain	___ Restless Legs	___ Inflammation	___ Discoloration	___ Spider Veins
___ Swelling	___ Hard Knot in Vein	___ Skin Rash	___ Heaviness	___ Varicose Veins
___ Ulcer/Wound	___ Cramps	___ Bleeding	___ Burning	___ Numbness/Tingling

Which Leg: ___ Left ___ Right ___ Both

How long have you noticed these symptoms? _____
Have you had any previous vein treatments? _____ Yes _____ No
If so, by whom and when? _____
Have you worn any type of support/compression stockings? _____ Yes _____ No
For what length of time? _____
What degree of compression? _____
Did they provide relief? _____

Symptoms worsen with:
___ Sitting ___ Standing ___Walking ___ Working ___ Lying Down ___ Beginning of Day ___ End of Day ___ Pregnancy

Symptoms improved with:
___ Elevation ___ Compression Hose ___ Medication ___ Walking ___ Rest ___ Beginning of Day ___ End of Day

Social History:

Alcohol:	___ Never	___ Rare	___ Occasional/Social	___ Daily
Smoking:	___ Never	___ Quit >10 Years	___ Quit 1-10 Years	___ Current Smoker
Caffeine:	___ Never	___ Some	___ Average	___ Excessive

Occupation: _____

Female Patients Only: Are you pregnant? ___ Yes ___ No Number of Pregnancies: _____ Number of Children: _____
Are you breastfeeding? ___ Yes ___ No

Surgical History:

___ Appendix Removal	___ Tubal Ligation	___ Joint Replacement	___ Hysterectomy
___ Cataract Removal	___ Tonsil Removal	___ Bone Fracture Repair	___ Hernia Repair
___ C-Section	___ Gallbladder Removal	___ Heart Bypass Surgery	___ Stent Placement

___ Other: _____

Medical History:

___ Coronary Artery Disease	___ Peripheral Vascular Disease	___ Blood Clot(s)	___ Cancer
___ High Blood Pressure	___ Diabetes	___ Stroke	___ Neuropathy
___ High Cholesterol	___ Migraines	___ Thyroid Disease	___ Arthritis

___ Other: _____

Allergies: _____

Family History:

___ Heart Disease ___ High Blood Pressure ___ Cancer ___ Peripheral Vascular Disease
___ High Cholesterol ___ Diabetes ___ Stroke ___ Varicose Veins
___ Other: _____

Current Medications:

Name	**Strength**	**Frequency** (once a day, twice a day)

Pharmacy Name: _____ **City:** _____

Review of Systems (Please circle all that apply):

Constitutional	Fever, Chills, Loss of Appetite, Weight Loss
HEENT	Vision Changes, Double Vision, Hearing Loss, Hearing Aids, Ringing in Ears, Ear Infections, Nose Bleeds, Cavities, Dentures, Bleeding Gums, Sores in Mouth, Hoarse Voice, Goiter, Thyroid Problems
Skin	Itching, Hives, Rash, Dryness, Bruising, Bleeding
Cardiovascular	Chest Pain, Heart Palpitations, Swollen Legs, Leg Cramps, Varicose Veins
Respiratory	Cough, Blood, Shortness of Breath, Asthma, Emphysema, Tuberculosis, Pneumonia
Gastrointestinal	Vomiting, Constipation, Diarrhea, Heartburn, Blood in Stool, Changes in Stool, Difficulty Swallowing, Jaundice, Liver Disease, Gallbladder Disease
Genitourinary	Urine Frequency, Pain with Urination, Blood in Urine, Incontinence
Neurological	Headaches, Dizziness, Numbness, Falls, Tremors, Stroke/TIA, Loss of Memory, Problems with Gait
Musculoskeletal	Weakness, Paralysis, Stiffness, Joint Pain, Swelling, Arthritis, Gout, Pain
Hematology	Anemia, Sickle Cell Disease, Hemophilia, Swollen Glands, Night Sweats, Itching, Bleeding Disorder
Psychiatric	Depression, Anxiety, Bipolar Disorder
Endocrine	Excessive Thirst, Excessive Urination, Intolerance to Heat/Cold, Diabetes, Hot Flashes
Allergy/Immune	HIV/AIDS, Hepatitis B, Hepatitis C, Hay Fever, Persistent Infection

VS P: _____ R: _____ BP: _____ WT: _____ HT: _____

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FAX: 706.850.3448
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Today's date: _____
Patient Name: _____
Nickname: _____
Date of birth: _____
Sex: _____
Soc. Sec. #: _____
Address: _____
City: _____
State: _____
Zip code: _____
Marital status: _____
Pharmacy: _____
_____

Responsible party: (self-unless patient is minor)
Responsible party: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Best Phone to call: _____
Contact email: _____
Emergency contact: _____
Relationship: _____
Emergency phone: _____
Primary care MD: _____
Referring Physician: _____
2nd Physician: _____

How did you hear about us? Billboard _____ Internet _____ Physician Referral _____ Magazine _____ Newspaper _____ Friend _____

HIPAA Choices:
Did you receive a copy of the HIPAA notice? Yes ____ No____ Allow voice message? Yes ____ No ____
Allow postal mail? Yes _____ No _____
Allow email: Yes _____ No _____
Allow call to cell? Yes _____ No _____
Who may we leave a message with? _____
Allow SMS (text message)? Yes _____ No _____

Occupation: _____
Employer: _____

Employer address: _____
City: _____
State: _____
Zip code: _____

Language: _____
Race/Ethnicity: _____

Family size: _____
Interpreter: _____
Seasonal Resident: _____

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YOU MUST BRING INSURANCE CARD AND PHOTO ID !!

Primary Insurance Provider: (Please provide a copy of your card)

Insurer: _____
Plan name: _____
Effective date: _____
Policy number: _____
Group number: _____
Co pay: _____
Subscriber: _____
Employer: _____
Address: _____
City: _____
State: _____
Zip code: _____

Subscriber: _____
(if self-do not complete the following lines)
Relationship: _____
Date of birth: _____
Soc. Sec. #: _____
Sex: _____
Subscriber address: _____
City: _____
State: _____
Zip code: _____
Subscriber Tele#: _____

Release and Assignment of Benefits:

Athens Vein & Thoracic Specialists is hereby authorized to furnish information to insurance carriers regarding my illness/ treatments and to collect all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or paid by the insurance. I am also responsible for any deductible, co pay, and/or coinsurance at the time services are rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

Signature of
Responsible party: _____ Date: _____