Thank you for choosing Missouri Vein Care. Please take a moment to fill out the following questions so we can better understand and treat your vein and circulation condition.

Patient Information

Date: ___________________________________

Full Name: ______________________________

Date of Birth: ____________________________

Sex: ____________________________________

Race: ___________________________________

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Language: _____________________

Social Security #:_________________________

Home Address: __________________________

City: ____________________________________

State: ___________________________________

Zip: _____________________________________

Home Phone: _____________________________

Work Phone: _____________________________

Cell Phone: ______________________________

Can we send you text message reminders for your appointments? ______________________

Email address: ____________________________

Can we send you email reminders for your appointments? ___________________________

Emergency Contact

Name:_____________________ Relationship:__________________ Phone Number:___________________

Acknowledgement of Missouri Vein Care financial policies and patient financial responsibility

____ ____

Signed (patient or parent if minor) Date

Acknowledgement of receiving HIPAA Statement

____ ____

Signed (patient or parent if minor) Date

Patient goes by: ____

How did you hear about us?

- □ Friend
- □ Family
- □ Current Patient
- □ Newspaper/Magazine
- □ Physician Referral
  Physician name: ________________
- □ TV Commercial
- □ Outreach Event
- □ Social Media
- □ Internet/Website
- □ Other ____________________

Did your physician assist with the referral? ____

Primary Care Physician: ____

OB/GYN (for women only): ____

Vein History

What is your main concern with your legs or circulation? ____________________________________

____

When did you first notice visible veins (approx. months/years)? ______________________________

When did you first notice symptoms (approx. months/years)? ________________________________

Have any of the symptoms worsened since they started?

- □ Yes
- □ No

If so, when did they start to worsen? ____

Does one leg bother you more than the other?

- □ Right
- □ Left
- □ Both equally

Symptom Assessment

In regards to your **right** leg; please mark if you have any of the following symptoms?

- □ Aching
- □ Burning feet
- □ Cold feet
- □ Burning sensation in legs
- □ Difficulty walking
- □ Discomfort
- □ Numbness or tingling sensation
- □ Decreased activity
- □ Foot cramps/Charlie horses
- □ Heavy legs
- □ Itching
- □ Leg cramps/Charlie horses
- □ Leg ulcers/sores
- □ Pain
- □ Reduced energy/fatigue
- □ Restless legs
- □ Swelling
- □ Symptoms worse in the evening or at night
- □ Throbbing
- □ Tired legs
- □ Trouble sleeping
- □ Weight Gain
- □ Other________________________
- □ No Symptoms

Where is the location of your **right** leg symptoms?

□ Ankle
□ Calf
□ Foot
□ Thigh
□ Whole leg
□ Other________________
□ No right leg symptoms

In regards to your **left** leg; please mark if you have any of the following symptoms?

□ Aching
□ Burning feet
□ Cold feet
□ Burning sensation in legs
□ Difficulty walking
□ Discomfort
□ Numbness or tingling sensation
□ Decreased activity
□ Foot cramps/Charlie horses
□ Heavy legs
□ Itching
□ Leg cramps/Charlie horses
□ Leg ulcers/sore
□ Pain
□ Reduced energy/fatigue
□ Restless legs
□ Swelling
□ Symptoms worse in the evening or at night
□ Throbbing
□ Tired legs
□ Trouble sleeping
□ Weight Gain
□ Other__________________________
□ No Symptoms

Where is the location of your **left** leg symptoms?

□ Ankle
□ Calf
□ Foot
□ Thigh
□ Whole leg
□ Other________________
□ No left leg symptoms

If your legs swell, please mark all that apply:

□ Swelling resolves overnight
□ Swelling is still present first thing in the morning
□ Swelling somewhat goes down overnight, but doesn't resolve
□ Diuretic medication has improved swelling
□ Only the right leg swells
□ Only the left leg swells
□ Both legs swell

What types of activities or physical mobility are reduced by your leg symptoms?

- □ Interferes with job performance due to leg symptoms
- □ Reduced activity and stamina due to poor sleep from leg symptoms
- □ Reduced exercise or walking due to discomfort.
- □ Requires leg elevation and leg rest
- □ Reduced ability to stand due to leg discomfort
- □ Unable to stand while cooking, childcare, or house care due to leg symptoms

Do your leg symptoms affect your sleep?

- □ Yes
- □ No

How many nights per week do your legs affect your sleep? _________________________

Leg symptoms affect sleep by (please mark all that apply):

- □ Awakening and/or staying asleep
- □ Initiating and/or falling asleep

How do you feel when you wake up in the morning?

- □ Rested
- □ Tired
- □ Exhausted
- □ Energized

How do you feel as the day goes on?

- □ Still energetic
- □ Tired and run down
- □ The same as in the morning
- □ Ready to sit down

What is your pain level when your symptoms are at their worst? (please circle pain rating that applies):

0- No symptoms
1- Very minor annoyance
2- Minor annoyance
3- Annoying enough to be distracting
4- Can be ignored if you are really involved in your work, but still distracting
5- Can’t be ignored for more than 30 minutes
6- Can’t be ignored for any period of time, but still able to work
7- Difficult to concentrate, sleep, or work
8- Physical activity severely limited
9- Crying, or moaning
10- Unbearable, requiring an ER visit

Interventions-Conservative Management

Before approving treatments, most insurance plans want to know if you have tried alternative therapy. Please provide as much detail as possible as this can help with insurance approval.
Please check all you have done to help relieve your leg symptoms:

Do you elevate your legs throughout the day or at the end of the day?

- □ Yes
- □ No

When did you start elevating your legs? (approx. months/years) ___________________________
How many days a week do you elevate your legs? ___________________ ____________________

Have you worn compression stockings?

- □ Yes
- □ No

If yes, when did you start wearing? (approx. months/years) _______________________________
How many days a week do you wear compression hose? _________________________________
Did compression stockings cause any problems that made you stop using them?

- □ Trouble getting them on due to limited strength or arthritis
- □ They were too hot.
- □ They caused numb feet or toes when wearing them.
- □ They rubbed on skin causing a rash or sore.
- □ They hurt when wearing them and could not tolerate the pain.
- □ They would not stay up and rolled down.
- □ Other ___________________________
- □ The patient was able to tolerate stockings without problems.

Did a physician recommend that you wear compression stockings? (If yes, give physician's name and date recommended)____

Have you tried exercising or physical activity to relieve your symptoms?

- □ Yes
- □ No

What type of exercise or activity have you tried? ____
How many days a week do you exercise or do physical activity? ___________________________
When did you first start exercising or being physically active? _____________________________

Have you tried medication(s) for your leg symptoms?

- □ Yes
- □ No

If so, which medication(s)?

- □ Naproxen or Aleve
- □ Ibuprofen or Motrin
- □ Aspirin
- □ Tylenol
- □ Prescription ______________
- □ Herbal __________________

When did you first start medication for your legs? (approx. months/years) ___________________

With these interventions, do you still have reduced mobility, stamina, or activity?

- □ Yes-If yes, please describe____
- □ No

Do you have to stop and rest at any time due to your leg symptoms or fatigue?

- □ Yes-If yes, please describe____
- □ No

Do your leg symptoms make any of these activities of daily living (ADL's) more difficult to perform or complete? (Select all that apply.)

- □ Childcare
- □ Cooking
- □ Exercise or being active
- □ Housekeeping, chores, or yard work
- □ Riding in a car/traveling
- □ Self-care(grooming, bathing, dressing)
- □ Shopping/errands
- □ Sleep
- □ Sitting for long periods of time
- □ Standing for long periods of time
- □ Working

Describe in more detail specific activities that are made more difficult by your leg symptoms:

____

____

If you are unable to do things because of your leg symptoms, how does this make you feel?

____

Have you had previous vein treatment?

- □ Yes
- □ No

If yes, which leg and type of treatment?

- □ Left leg
- □ Right leg
- □ Laser ablation
- □ Vein stripping/ligation
- □ Sclerotherapy

When and where did you have treatment(s) (approx. year)? ___________________________________

Were you satisfied with the results?

- □ Yes
- □ No-Please share why you were not satisfied:____
- □ Somewhat

Does the patient have a family history of vein disease?

- □ Yes-If yes, who? _____________________________
- □ No

Does the patient or their family have a history of blood clots in their legs?

- □ Yes-If yes, who? _____________________________
- □ No

Are you able to tolerate Aleve/Ibuprofen? ____

Have you ever been told you have a hole in your heart such as ASD, VSD or PFO? ___________________

The procedure we perform will involve needle sticks. Does this make you feel anxious? ______________

PATIENT MEDICAL INFORMATION

Allergies

Do you have any drug/medication or latex allergies?

- □ Yes
- □ No

If yes, please list:

____

Medications

Please list all medications and supplements you are taking including dosages and frequencies below:

____
____
____

Are you currently taking Coumadin/Warfarin, Xarelto, Eliquis, or any other blood thinning medication?

- □ YES
- □ NO

Pharmacy____

Medical History

Please mark all that apply:

- □ Arthritis
- □ Coronary Artery Disease (CAD)
- □ Back pain
- □ Deep Vein Thrombosis (DVT)
- □ Generalized aches and pains
- □ Hypertension
- □ Currently pregnant (due date_______)
- □ Stroke or TIA's
- □ Asthma
- □ Congestive Heart Failure
- □ Dementia
- □ HIV
- □ Kidney Disease
- □ Peripheral Artery Disease (PAD)
- □ Ulcer (GI-stomach)
- □ Back Problems
- □ COPD
- □ Diabetes
- □ Headaches
- □ Heart Attack
- □ Pulmonary Embolism (PE)
- □ Currently breastfeeding (anticipated stop date ________________________)
- □ Cancer (type____________________)
- □ Acid reflux (GERD)
- □ Hepatitis (B or C)
- □ Migraines
- □ Sleep Apnea
- □ Clotting disorder_________________
- □ Bleeding disorder_________________
- □ Other (please list) ________________

Surgical History

- □ Ankle Surgery
- □ Hip Surgery
- □ Back Surgery
- □ Knee Surgery
- □ Heart Surgery
- □ Foot Surgery
- □ Heart Stents
- □ Arterial Surgery
- □ Gastric Surgery

Other major surgeries pertaining to leg symptoms (please list): ___________________________________

Social History

Do you smoke?

☐ Yes
☐ No

Marital Status:

☐ Married-Spouse's name: ___________________________________
☐ Single
☐ Widowed
☐ Divorced
☐ Significant other/partner-Name: ___________________

Children:

☐ Yes- Names & ages: _______________________________________
☐ No

Profession (describe position current or past if retired): ____
Employer (current or past if retired): ____
Is the patient retired? (If yes, describe prior work before retirement):_____________________________
Hobbies/Leisure activities/Interests (list):____
Where did you grow up? ____
Any big events to share? (vacation, family events, job) ____

Patient signature: ____ Date ____________________

Reviewed by: ____ Date ____________________

Missouri Vein Care Financial Policy

I have financial responsibility for services at MVC. I understand that my insurance may provide coverage for these services, but I am responsible for all fees associated with evaluation and treatment. If Missouri Vein Care (MVC) participates with your insurance plan, MVC will file your insurance for you with any copay/deductible due from you at the time of service. I will be responsible for payment of my annual insurance deductible, co-insurance and co-pays. If MVC does not participate with my insurance plan, I understand that I am financially responsible for all charges and understand that MVC will ask for payment in full at time of service and file your insurance as a courtesy with any reimbursement sent to you.

I agree to allow information to be forwarded to allow payment. I request that payment under my health insurance plan be made to MVC or the provider named on the bills for services furnished me and authorize MVC to release to the Social Security Administration, insurance clearinghouses, insurance companies or Medicare any information needed to allow this claim to be paid. I permit a copy of this authorization to be used in place of the original.

I assign all payments to MVC. I assign all payments for services at MVC, including Medicare, Medicaid, private insurance and any other health plan to Missouri Vein Care. If my insurance sends me payment, I agree to endorse the check and send it along with a copy of the explanation of benefits to MVC immediately. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Non-covered Medicare and Medicaid services Medicare and other health plans may not cover some exams or services. Those non-covered services may be your responsibility. As MVC determines specifics of your insurance plan, MVC will inform you of which services are not covered. Please remember that the federal government or your health plan determines which services are covered, not MVC.

I am responsible to know my insurance plan. I understand that it is my responsibility to understand my insurance policy's provisions including what services are covered, the need for a primary care referral, the deductible, the co-insurance or co-payments that may apply. I understand that co-payments and co-insurance are due at the time of service. I understand it is my responsibility to update MVC of any changes to my insurance.

Financial responsibility for Minors: Adults accompanying children or requesting services are responsible for payment, regardless of who has custody or who carries the insurance on the patient.

Acknowledgment of Missouri Vein Care financial policies and patient financial responsibility

Signature:____ Date:__________________________

Medical Information Release Form

(HIPAA Release Form)

Name: ____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and financial information. This information may be released to:

[ ] Spouse______________________________________

[ ] Child(ren)____________________________________

[ ] Other_______________________________________

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (day)___________________ between (time)_____________________

Signed: ____ Date:____/____/____

Witness: ____ Date: ____/____/____