ATLANTIC VEIN INSTITUTE | 7 Graf Road, Suite 1B Newburyport, MA 01950
tel: 978-462-8006 | fax: 978-268-5020 | info@AtlanticVeinInstitute.com | www.AtlanticVeinInstitute.com

Demographic Information

Contact Information

Patient Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female
Address: _____
City: _____ State: _____
Zip: _____ Social Security Number: NOT REQUIRED
Home Phone _____ Work Phone _____
Cell Phone: _____ Other Phone: _____
Which phone number should we use first? _____
Email: _____
When we confirm your visit, how would you like us to reach you? ☐Phone ☐Postcard ☐E-mail

Emergency Contact Information

Name: _____
Phone: _____
Relationship to you: _____

Insurance Information

How will you pay for medical services? ☐Insurance ☐Self pay ☐ Other _____

Primary Insurance

Insurance Name: _____
Group #: _____
ID/Member #: _____
Insurance Type: _____

Secondary Insurance

_____
_____
_____
_____

Scheduling Preferences

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐AM ☐PM ☐No preference

Additional Information

How did you hear about us?

I hereby authorize my insurance benefits to be paid directly to Atlantic Vein Institute in the name of David J. Swierzewski, MD for services received. I understand that my insurance carrier may pay less or none of the charges for these services and that I am responsible for all charges and responsible to pay in full for non-covered services. I also authorize the release of pertinent medical information necessary to process my insurance request. I acknowledge that I have been made aware of the privacy policy of this office as it pertains to the privacy and confidentiality of my medical records. All questions contained in this questionnaire are strictly confidential and will become part of my medical record.

Signature: _____ Date: _____

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Medical Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Primary care provider: _____

Primary care provider address: _____

Primary care provider phone: _____

Vein History

Do your legs bother you? ☐Yes ☐No If yes, please check all that apply and note which leg in the comments:

- ☐ Aching
- ☐ Cramping
- ☐ Throbbing
- ☐ Pain
- ☐ Swelling
- ☐ Itching
- ☐ Heaviness
- ☐ Ulcers
- ☐ Numbness

Other/Comments:

Have you ever worn compression stockings? ☐Yes ☐No If yes, when and for how long?

Have you had past vein treatment or had leg veins examined by a physician? ☐Yes ☐No If yes, please describe:

Do you ever take Aspirin, Tylenol, or Ibuprofen for your leg symptoms? ☐Yes ☐No

Do your legs prevent you from doing any activities (e.g. standing for long periods, swimming, wearing shorts, sleeping)? ☐Yes ☐No If yes, please describe:

Have you had injury to your legs requiring casting? ☐Yes ☐No

Please check any of the medical conditions below that you have experienced:

- ☐ Deep Vein Thrombosis (DVT)
- ☐ Superficial Vein Phlebitis
- ☐ Venous Stasis Ulcer
- ☐ Bleeding from Varicose Veins
- ☐ Vein Treatment
- ☐ Other

Medical History

Do you see a doctor regularly for any medical condition? ☐Yes ☐No If yes, please describe:

Please check any health or disease related issues you might have:

- ☐ AIDS
- ☐ Anemia
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Stroke
- ☐ Ulcers
- ☐ Other? _____

Medical Information

Have you had any serious injuries? ☐Yes ☐No If yes, please list the date and type of injury:

Past Surgeries

Please list past surgeries:

Family History

	Major Illness	Age	Deceased?
Mother:	_____	_____	☐Yes ☐No
Father:	_____	_____	☐Yes ☐No
Sibling 1:	_____	_____	☐Yes ☐No
Sibling 2:	_____	_____	☐Yes ☐No
Sibling 3:	_____	_____	☐Yes ☐No

Social History

Current/Past occupation?: _____ Marital status: _____

Do you smoke? ☐Yes ☐No How much? Quit date? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much? _____

Do you exercise? ☐Yes ☐No If yes, please describe: _____

Medication

Please list current medications:

OB History (Women only)

Is there a chance that you are pregnant? ☐Yes ☐No How many times have you been pregnant? _____

How many children have you birthed? _____ Complications?

Allergies

Please list allergies:

Medical Conditions *(circle any that apply)*

General Health: ☐Recurrent infections/fever, ☐fatigue, ☐recent weight gain or loss, ☐night sweats, ☐decreased appetite. Comments:

Emotional: ☐Depression, ☐anxiety attacks, ☐crying spells, ☐alcohol/drug problems, ☐problems falling asleep, ☐nervousness, ☐suicidal thoughts. Comments:

Eyes: ☐Wear glasses or contacts, ☐eye infections, ☐blurred vision. Comments:

Medical Conditions *continued*

Head, Ears, Nose, Mouth, Throat:	Ear infections, headaches, fullness in head, sore throat, nose bleeding. Comments:
Heart:	Chest discomfort, tightness, heart murmur, swollen ankles, shortness of breath, rheumatic fever, high blood pressure. Comments:
Lungs:	Difficulty breathing, cough, wheezing, cough blood or mucus, sleep on more than one pillow. Comments:
Lymphatic/Blood Vessels:	Excessive bleeding, bruise easily, swollen lymph nodes. Comments:
Muscle/Bone/Joints:	Joint pain, stiffness, swelling, muscle pain, muscle cramping or spasms, neck/back pain. Comments:
Nervous System:	Fainting or loss of consciousness, convulsions, seizures, dizziness, memory changes. Comments:
Reproductive:	Burning pain when urinating, frequent urination, sudden impulse to urinate, irregular periods, clots, cramps, prostate problems. Comments:
Skin/Breasts:	Sore, rash/itching, lumps/growths, changes in moles, hair loss, swollen glands, tenderness or pain in breasts, discharge from breasts. Comments:
Stomach and Intestinal:	Special diet, change in appetite, heartburn, nausea/vomiting, problems swallowing, black stools, ulcers, constipation, use antacids. Comments:
Other:	Please describe any other medical conditions you may have:

Additional Medical Information

Please share any details about your health that you feel may be relevant and not previously mentioned?: