



VICTORIA VEIN & SURGERY CLINIC

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____
 Sex: M [] F [] *First* *Middle Initial* *Last*

Email address: _____

Patient's SS#: _____ Date of Birth: ____/____/____ Race: _____

Address: _____ City: _____ State _____

Zip _____ - _____ Home #() _____ - _____ Cell #() _____ - _____ Work #() _____ - _____

RESPONSIBLE PARTY *(If Minor /Responsible Party)*

Responsible Party Name (if different than patient) _____
 Sex: M [] F [] *First* *Middle Initial* *Last*

Name: _____ DOB ____/____/____ SS# _____ - _____ - _____

Emergency Contact: _____ Home #() _____ - _____
 Relationship _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **Name of Insured:** _____
 ID or Policy Number: _____ **Group Number:** _____
 Insurance Phone # _____ **Effective Date:** _____

Secondary Insurance Name: _____ **Name of Insured:** _____
 Id or Policy Number: _____ **Group Number:** _____
 Insurance Phone # _____ **Effective Date:** _____

INSURANCE AUTHORIZATION & ASSIGNMENT:

I authorize Sean M. Hamilton, MD with Victoria Vein & Surgery Clinic to furnish information to insurance carriers concerning my medical condition and care. I assign to Sean M. Hamilton, MD all payments for medical services rendered to me or my dependents. I also request payment of government benefits to the party who accepts assignment. This authorization is valid as long as I am a patient of Sean M. Hamilton M.D.

Any person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event such costs are not incurred on behalf of patient and in the even such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fee's, collection agencies and interest.

Signature _____
Signature Date
 The signature is of the: ___ Patient ___ Parent of Minor ___ Legal Guardian ___ Patient's Power of Attorney

We reserve the right to charge a no-show fee of \$10.00 if you fail to notify our office of your cancellation within 24 hours of your appointment. Insurance will not cover this fee.

Victoria Vein & Surgery Clinic

Patient Medical History

Name: _____ **Date of Birth:** _____

Patient Referred by: _____ **Reason for Referral:** _____

Race: Check the appropriate box

White(Non-Hispanic)___ Hispanic___ Black___ Asian___ American Indian___ Pacific Islander___ Other___

Primary Care Physician _____ **Pharmacy** _____ **Phone:** _____

Past Medical History: Please list any medical problems you have:

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Surgical History/ Trauma History: List any operations or injuries along with month, year and hospital

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

Have you or any family members ever had a reaction to anesthesia? _____ **Bleeding Problems?** _____

Medications: List the medications you are currently taking along with the dosages, include nonprescription items such as St. John's Wort, dietary supplements, diet pills, cold and flu medications, etc.

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Have you taken the following in the last month? Prednisone ___ Coumadin ___ Aspirin/ Motrin/ Naprosyn ___

What meds are you ALLERGIC to? _____

Review of Systems: Check the appropriate box if you have had these symptoms recently

Yes No	Yes No	Yes No	Yes No
___ Fevers	___ Calf Pain	___ Upper Abdominal Pain	___ Nipple discharge
___ Night Sweats	___ Short of breath (SOB)	___ Lower Abdominal Pain	___ Headache or migraine
___ Fatigue	___ SOB with ex	___ Painful urination	___ Room spinning
___ Vision changes	___ SOB at night	___ Blood in urine	___ Seizures
___ Double vision	___ Wheezing	___ Straining on urination	___ Passing out
___ Hearing loss	___ Cough, sputum	___ Kidney stones	___ Numbness or tingling
___ Ringing in ears	___ Coughing blood	___ Pelvic pain	___ Memory loss
___ Ear pain or drainage	___ Diarrhea	___ Vaginal discharge/bleeding	___ Anxiety
___ Bloody nose	___ Constipation	___ Joint or muscle pain	___ Depression
___ Nasal discharge	___ Stool incontinence	___ Decreased mobility, weakness	___ Suicidal thoughts
___ Sinusitis	___ Black tar-like stools	___ Joint swelling	___ Excessive hair growth
___ Sore throat	___ Bloody stools	___ Skin rash	___ Excessive thirst
___ Hoarseness	___ Difficulty swallowing	___ Itching	___ Excessive urination
___ Oral ulcers	___ Heartburn	___ Mole changes	___ Easy bruising
___ Chest pain	___ Nausea	___ Loss of hair	___ Bleeding tendency
___ Palpitations	___ Vomiting	___ Difficulty w/ nails	___ Swollen nodes
___ Ankle swelling	___ Irregular Pulse	___ Vomiting blood	___ Breast lumps, pain

Menstrual History: Are you pregnant? ___ Number of Pregnancies ___ Live births ___
Miscarriages ___ Age of first pregnancy ___ Do you take birth control pills? ___ Age of Menopause ___

Social History: Marital status: _____ Number of children _____ International travel? _____

Occupation: _____ Do you do heavy lifting on a daily basis? _____

Cigarette Smoking: I have smoked _____ packs per day for _____ years. Quit smoking in _____ Drug use? _____

Please describe your alcohol intake: ___ None ___ Occasional ___ 1-2 drinks per day ___ >2 drinks per day

Family History: Check the box if you have first degree relatives with the following cancers (Ca) or diseases:

Breast Ca ___ Ovarian Ca ___ Colon Ca ___ Skin Ca ___ Lymphoma ___ Leukemia ___ Inflam. Bowel Disease ___

Brain tumors ___ Heart disease ___ Thyroid Disease ___ Parathyroid disease ___ Other _____



VICTORIA VEIN & SURGERY CLINIC

Consent to Photograph for Medical Communication with Insurance Company

Patient Name: _____ Date: _____

The undersigned authorizes Victoria Vein & Surgery Clinic to take and reproduce photographs of the above named person in communication with diagnosis, care and treatment. Use of such materials and the person's name is also authorized for use in dealing with the named person's insurance company, including filing claims, medical necessity and appeals with said insurance company.

_____ Initial to indicate that you have read, understand, and approve authorization as stated above.

I release the Victoria Vein & Surgery Clinic and Sean M. Hamilton, M.D., employees, and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.

Patient's Signature: _____ Date: _____

Phone Number: _____

Legal Guardian' Signature if patient is under 18: _____

Witness' Signature: _____ Date: _____

I, _____ have read and understand the HIPAA Notice of Privacy Practices of Dr. Sean M. Hamilton's office.

_____ I want a copy of the HIPAA Privacy Policy

_____ I do not want a copy of the HIPAA Privacy Policy

I have given permission for the office of Dr. Sean M. Hamilton to discuss my medical history/condition with the following person(s):

Name: _____ Limited Time/ Date ending _____ or Until rescinded _____

Patient Signature: _____ Date: _____

Victoria Vein & Surgery Clinic

Patient please complete questions 1-12

Patient Name: _____ Date of Birth: _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery Yes No
If yes, when and which leg? _____
2. Have you ever had vein injections? Yes No
If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? Yes No
If yes, which leg and when? _____
4. Have you ever had phlebitis? Yes No
If yes, which leg and when? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- | | | |
|------------|------------------------------|-----------------------------|
| Father | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

1. Do you experience any of the following in your legs?

- | | | | | | | |
|--------------------|------------------------------|-------------------------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------------|
| Aching/pain? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Heaviness? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Tiredness/fatigue? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Itching/burning? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Swollen ankles? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Leg cramps? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Restless legs? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Throbbing? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |



VAS Scale -Rate the intensity of pain _____ Persistent Yes No

2. Have your veins gotten worse in recent months? Yes No
Describe: _____

3. Do you take any medication for pain (i.e., Advil, Motrin) Yes No
If yes, what medication(s) do you take and how many times/mgs per day? _____

4. Do you elevate your legs to relieve discomfort? Yes No
If yes, how long per day do you elevate and does it provide relief? _____

5. Do you exercise? Yes No
If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? Yes No
If yes, what type and gradient? How long have you worn them? _____

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)? Yes No
If yes, do they provide relief? _____

8. Do you have any problem walking? Yes No
If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise) _____

9. What type of work do you do? _____
How long do you stand (hours per day) at work? _____ At home? _____
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours) _____

10. Have you ever had any test(s) done on your veins? Yes No
If yes, when and what type of test and where on the leg? _____

11. Were you diagnosed with saphenous vein reflux? Yes No

12. Name of referring Physician and how long have you been under his care for treatment of this condition? _____

Patient Signature: _____ Date: _____