

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 ___ Inflamm. 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: _____