TOTAL VEIN CARE
AT CORINTH LASER CENTER ANGEL A. RODRIGUEZ, M.D.

Demographics

Patient Name:_____Today's Date_____

Address: _____

City, St, Zip _____

Primary Phone: _____ Cell: _____ Work:_____

DOB: _____ Social Security #: _____Male/Female_____

Email:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self- Employed ☐ Retired ☐ Unemployed

Place of Employment: _____ Referring Physician: _____

Emergency Contact: _____Phone:_____

How did you hear about us: ☐ Newspaper ☐ Magazine ☐ Internet ☐ Friend ☐ Billboard

Insurance Information

Primary Insurance _____

ID# __See Card_____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birth date _____ Subscriber SS#_____

Secondary Insurance _____

ID# ___See Card_____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birthdate _____ Subscriber SS#_____

Family Doctor _____ Phone # _____

Are you currently being treated by any other physician(s)?
☐No ☐Yes *(If Yes; Please list with phone number)*

Date of last physical exam:_____

I hereby authorize the above practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.
I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance.
I understand that the above practice is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.
I understand that the above practice is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, the above practice may take action to collect its charges, which includes payment being charged to my credit card.

Signature _____ Date _____

List of Medications (below)	Dosage	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Pharmacy _____Phone # _____

List ALL Allergies _____

Mark any of the following conditions you or a family member has EVER experienced?

Condition	**Self**	**Family**	**Please Explain**
Hives	☐	☐	_____
Asthma	☐	☐	_____
COPD	☐	☐	_____
Atrial fibrillation	☐	☐	_____
Murmur	☐	☐	_____
Heart Disease	☐	☐	_____
Hepatitis	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke/seizures/TIA	☐	☐	_____
Diabetes (type)	☐	☐	_____
Arthritis	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Street Drug Usage	☐	☐	_____
Migraine Headache	☐	☐	_____
Autoimmune Disorder	☐	☐	_____
Fainting or Dizziness	☐	☐	_____

Universal New Patient Intake Form

Are you pregnant? ☐No ☐Yes Number of Pregnancies _____Number of Births _____

Decreased appetite	☐ No ☐ Yes
Change in weight	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
High cholesterol	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Fevers	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Decreased vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Temporary blindness	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Detached retina	☐ No ☐ Yes
Temporal arteritis	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Seizure	☐ No ☐ Yes
Fainting	☐ No ☐ Yes
Headache	☐ No ☐ Yes
Migraine	☐ No ☐ Yes
Stroke	☐ No ☐ Yes
Numbness in limbs	☐ No ☐ Yes
Slurred speech	☐ No ☐ Yes
Decreased memory	☐ No ☐ Yes
Ankle swelling	☐ No ☐ Yes
Atrial fibrillation	☐ No ☐ Yes
Labored breathing	☐ No ☐ Yes
Dizziness	☐ No ☐ Yes
Congenital heart dis.	☐ No ☐ Yes
Rheumatic heart dis.	☐ No ☐ Yes
Murmur	☐ No ☐ Yes
Loss of consciousness	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes
Chest discomfort	☐ No ☐ Yes
Unable to urinate	☐ No ☐ Yes
Painful urination	☐ No ☐ Yes
Prostate problems	☐ No ☐ Yes
Kidney/bladder dis.	☐ No ☐ Yes
Decr. urine stream	☐ No ☐ Yes
Kidney failure	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Anxiety	☐ No ☐ Yes
Confusion	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Delusions	☐ No ☐ Yes
Easy bruising	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Clotting disorder	☐ No ☐ Yes
Bleeding disorder	☐ No ☐ Yes
Pain in leg at rest	☐ No ☐ Yes
Leg pain when walking	☐ No ☐ Yes
Slow healing leg wound	☐ No ☐ Yes
Sensitivity to cold	☐ No ☐ Yes
Arterial disease	☐ No ☐ Yes
History of gangrene	☐ No ☐ Yes
Change in moles	☐ No ☐ Yes
Itching	☐ No ☐ Yes
Rash	☐ No ☐ Yes
Dry skin	☐ No ☐ Yes
Chronic skin problems	☐ No ☐ Yes
Sore throat	☐ No ☐ Yes
Sinus drainage	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes
Discharge from ears	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Hearing loss	☐ No ☐ Yes
Ringing in ears	☐ No ☐ Yes
Painful swallowing	☐ No ☐ Yes
Indigestion	☐ No ☐ Yes
Vomiting	☐ No ☐ Yes
Vomiting blood	☐ No ☐ Yes
Gall bladder problems	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Jaundice	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Bloody stools	☐ No ☐ Yes
Change in stool color	☐ No ☐ Yes
Change in bowel habits	☐ No ☐ Yes

Cough	☐ No ☐ Yes
Respiratory pain	☐ No ☐ Yes
COPD	☐ No ☐ Yes
Prod. of sputum	☐ No ☐ Yes
Coughing blood	☐ No ☐ Yes
Apnea	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes
Pneumonia	☐ No ☐
Bone/joint deformity	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle aches	☐ No ☐ Yes
Limited motion	☐ No ☐ Yes
Knee replacement	☐ No ☐ Yes
Hip replacement	☐ No ☐ Yes
Spinal problems	☐ No ☐ Yes
Thyroid disorder	☐ No ☐ Yes
Diabetes w/ insulin	☐ No ☐ Yes
Diabetes -no insulin	☐ No ☐ Yes
Extreme appetite	☐ No ☐ Yes
Extreme thirst	☐ No ☐ Yes
Lupus	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes

FEMALE ONLY

Irregular periods	☐ No ☐ Yes
Breast problems	☐ No ☐ Yes
Menopause	☐ No ☐ Yes
Last pelvic exam	_____ mo / year
Last period	_____ year

OFFICE USE ONLY

_____
_____

Habits:

Do you drink alcoholic beverages? ☐No ☐Yes (*#/week* _____*)*

Do you now or have you ever used tobacco? ☐No ☐Yes *(Packs/week* _____*)*Quit Date, if applicable _____

Do you exercise regularly? ☐No ☐Yes (*#of days / week* _____*)*

Do you currently wear compression hose: ☐ Yes How long;_____ ☐ No

Vein History

When did you first notice your enlarged or discolored veins?_____

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg(s), (*Circle)* Right Leg / Left Leg / Both

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long?_____

Do you have a f**amily** history of vein problems?

☐ Varicose Vein	☐ No ☐ Yes, Whom _____
☐ Spider Veins	☐ No ☐ Yes, When _____
☐ Deep vein thrombosis	☐ No ☐ Yes, When _____
☐ Leg Ulcers	☐ No ☐ Yes, When _____
☐ Pulmonary Embolus	☐ No ☐ Yes, When _____
☐ Phlebitis	☐ No ☐ Yes, When _____

Please ☑ next to the symptoms that apply to **you:**

☐ Aching leg(s)	☐ Appearance	☐ Burning	☐ Cramps
☐ Dull Pain	☐ Heaviness	☐ Itching	☐ Leg Ulcers
☐ Restless Legs	☐ Sharp Pain	☐ Swelling	☐ Throbbing
☐ Tiredness	☐ Other: _____		

Phlebitis (Clot in surface veins in legs)?	☐ No ☐ Yes, When _____
Deep Vein Thrombosis (Clot in deep veins)?	☐ No ☐ Yes, When _____
Pulmonary Embolus (Blood clot in lungs)?	☐ No ☐ Yes, When _____
Bleeding from veins?	☐ No ☐ Yes, When _____
Have you had sclerotherapy before?	☐ No ☐ Yes, When _____
Venogram (Vein X-Ray)	☐ No ☐ Yes, When _____
Have you ever had vein surgery?	☐ No ☐ Yes, When _____
Hemorrhoids?	☐ No ☐ Yes, When _____
IV drug use?	☐ No ☐ Yes, When _____
AIDS/HIV/hepatitis?	☐ No ☐ Yes, When _____
Trauma/injury to your legs?	☐ No ☐ Yes, When _____
Clotting disorder?	☐ No ☐ Yes, When _____