VEGAS VALLEY VEIN INSTITUTE

2450 West Horizon Ridge Parkway #100
Henderson, Nevada 89052

Venous Health History Form

Patients please complete the following questions. Provide estimates for date of occurrence.

Patient Name: _____ Date of Birth: _____

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	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

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

Aching/ pain?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Heaviness?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Tiredness/ fatigue?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Itching/ burning?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Swollen ankles?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Leg cramps?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Restless legs?	☐ Yes	☐ No	☐ One leg	☐ Both legs
Throbbing?	☐ Yes	☐ No	☐ One leg	☐ Both legs

   Other? _____

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 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? ☐Yes ☐No

8. Do you have any problem walking? ☐Yes ☐No
   If yes, describe how it interferes with your activities of daily living, which activities? _____
   _____

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: _____
   _____

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 or her care for treatment of this condition?
    _____

Patient Signature: _____ Date: _____

IRWIN B. SIMON, M.D., F.A.C.S.

DATE _____ **ACCT #** _____ **NAME** _____

MEDICAL HISTORY

SOCIAL HISTORY

Where were you born? _____ Age: _____ Height: _____ Weight: _____

Level of Education _____ Marital Status _____

Occupation _____

HABITS

Have you ever smoked or used chewing tobacco? _____ If cigarettes, how many packs a day? _____ How many years? _____ When did you quit? _____

Do you consume alcoholic beverages? _____ Type _____ How much? _____ How often? _____ How many years? _____ When did you quit? _____

Medications: List **ALL** current medications, including over the counter. _____

_____

_____

FAMILY HISTORY

Age of father _____ If deceased, age at death _____. Condition of health or cause of death _____

Age of mother _____ If deceased, age at death _____. Condition of health or cause of death _____

Number of brothers _____ Condition of health or cause of death _____

Number of sisters _____ Condition of health or cause of death _____

Number of children _____ Condition of health or cause of death _____

FAMILY HEALTH HISTORY

Check the boxes appropriate for you or your family member(s):

	SELF	SIBLING	CHILD	MOTHER	FATHER	GRANDPARENT	OTHER
Cancer: if yes, specify type							
Tuberculosis							
Diabetes							
Hypertension							
Kidney Disease							
Heart Attack or Heart Disease							
Angina							
COPD/Lung Disease							
Rheumatic Fever							

OPERATIONS

List **ALL** your operations in chronological order giving approximate year in which the surgery was performed: _____

_____

_____

ALLERGIES / MISCELLANEOUS

Check if you have any of the following: _____ Hay Fever _____ Asthma

_____ Food Allergies List _____

_____ Medication Allergies List _____

Bleeding tendency: _____ Yes _____ No. If yes, please explain _____

Have you ever taken Cortisone or steroids? _____ Yes _____ No. If yes, when _____. Why? _____

When did you last take them? _____

OVER

10. Systems review: Check if you **currently have** any of the following:

A. HEENT:

- ☐ Headache
- ☐ Dizziness
- ☐ Convulsions
- ☐ Nervousness
- ☐ Poor hearing
- ☐ Ear infections
- ☐ Ringing in the ears
- ☐ Poor vision
- ☐ Wear glasses
- ☐ Nose bleeds
- ☐ Sinusitis
- ☐ Hoarseness

B. RESPIRATORY:

- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Shortness of breath
- ☐ Cough
- ☐ Spitting up blood
- ☐ Chest pain

C. HEART:

- ☐ Murmur
- ☐ Heart attack
- ☐ Palpitations
- ☐ High blood pressure

D. GASTROINTESTINAL:

- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Excess gas
- ☐ Bloating after meals
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Peptic ulcer
- ☐ Abdominal pain
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Jaundice
- ☐ Gallbladder disease
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in/on the stools
- ☐ Black tarry stools
- ☐ Hemorrhoids

E. GENITO-URINARY:

- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Urinate at night. If so, how often
- ☐ Kidney stones
- ☐ Blood in urine

F. NEUROMUSCULAR:

- ☐ Rheumatism
- ☐ Arthritis
- ☐ Back trouble
- ☐ Ruptured disc

G. SYSTEMIC:

- ☐ Weight loss. If so, how much _____
- ☐ Weight gain. If so, how much _____
- ☐ Anemia
- ☐ Tiredness
- ☐ Weakness

H. MENSTRUAL: (for Women)

Age of onset of menstrual periods _____

Number of pregnancies _____ Age at first delivery _____

Number of miscarriages _____

Number of stillbirths _____

When was your last menstrual period _____

Was it normal _____ Are your periods regular _____

Do you have bleeding or spotting between periods _____

When was your last pelvic and Pap smear _____

Irwin B. Simon, M.D., F.A.C.S.

Who referred you to Dr. Simon? _____

PATIENT: This section refers to the PATIENT ONLY.

Name _____ Sex _____ Age _____ Birth Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ SS# _____

Cell Phone _____ Email: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer _____ Occupation _____

Work Address _____ Work Phone ( ) _____ Ext _____

City _____ State _____ Zip _____

SPOUSE/PARENT INFORMATION:

Name _____ Relation to Patient _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ SS# _____

Cell Phone _____ Birth Date _____

Employer _____ Occupation _____

Work Address _____ Work Phone ( ) _____ Ext _____

City _____ State _____ Zip _____

INSURANCE:

Primary Insurance: _____ **Secondary Insurance:** _____

ID#: _____ Group # _____ ID#: _____ Group # _____

Name of Insured: _____ Name of Insured: _____

DOB for Insured: _____ DOB for Insured: _____

PERSONAL GUARANTEE: I hereby guarantee payment of all charges incurred by me during the course of my examination, surgery or other treatment by Dr. Irwin B. Simon and/or his associates. I agree to pay all co-pays, percentages and/or deductibles that are deemed patient liability by my insurance carrier. Should my account fall into default, I agree to be responsible for any and all collection fees. _____ Initial

INSURANCE DISCLOSURE: I affirm that I have properly listed my Primary Insurance and any Secondary Insurance. I understand that failure to do so may result in denial of payment y the insurance carrier(s). Should this occur, I affirm that I am personally responsible for all charges as noted above under my personal guarantee of payment. _____ Initial

DISCLOSURE AFFIDAVIT: I certify that the information given by me above is correct and complete as I know it. I have supplied the office staff with my current insurance cards and a picture identification card to be copied and kept as part of my record with this office. _____ Initial

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Irwin B. Simon, M.D. and/or his associates to release any information acquired in the course of my examination, surgery, or other treatment to insurance companies or other medical professionals as deemed appropriate by Dr. Simon and/or his associates. I authorize payment of medical benefits directly to Dr. Simon. _____ Initial

Signature (Patient, or parent, if minor) _____ Date _____