MOUNTAIN
• VEIN CARE •
WHERE PHYSICIAN-PROVIDED CARE & EXPERIENCE MATTER

PATIENT REGISTRATION FORM

Date:_____ / _____ / _____ Name:_____
Last First M.I.

Home Address:_____
City State Zip Code

Mailing Address (if different):_____
City State Zip Code

Home Phone#:_____ Work#:_____ Cell#:_____

Phone# you prefer we contact you (circle) Home Work Cell E-Mail:_____

DOB: _____ / _____ / _____ SS#:_____ Age:_____ Sex:____ Marital Status:_____

Employer:_____ Occupation:_____

Employer Address:_____
City State Zip Code

Meaningful Use Data (Check one in each category**):**

Ethnicity: ☐Declined to specify ☐Hispanic or Latino ☐Not-Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Declined to specify ☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander ☐Not Hispanic or Latino ☐Other Race ☐White

Preferred Language: ☐Declined to specifiy ☐Chinese ☐English ☐French ☐German ☐Hindi ☐Italian ☐Japanese ☐Portuguese ☐Russian ☐Spanish

Primary Insurance (please present your primary insurance card at time of check-in)

Insurance Provider:_____ ID#:_____ Group#:_____

Secondary Insurance (please present any secondary insurance card(s) at time of check-in)

Insurance Provider:_____ ID#:_____ Group#:_____

Contacts:

Primary Care Provider:_____ Referring Provider: _____

Emergency Contact:_____ Relationship:_____

Home Phone#:_____ Work#:_____ Cell#:_____

How did you hear about Mountain Vein Care? (Circle all that apply):
Internet-Search Website Magazine Newspaper Radio TV Yellow-Pages Referral-to-MVC

Patient Signature: _____

Printed Name: _____ Date Signed: _____ / _____ / _____

MOUNTAIN VEIN CARE
WHERE PHYSICIAN-PROVIDED CARE & EXPERIENCE MATTER

VEIN HEALTH & HISTORY FORM

Date:____ /_____ /_____ Patient Name:_____
Last First M.I.

DOB: ____/_____ / _____ Are you requesting a vein evaluation for medical reasons? Yes No

What is your chief complaint or medical reason for having a vein consultation?_____

Indicate which of the following signs or symptoms you have experienced: (circle all that apply)

Symptom	Left Leg	Right Leg	Symptom	Left Leg	Right Leg
Burning	L	R	Generalized Leg Swelling	L	R
Itching	L	R	Pulmonary Embolism (PE)	L	R
Tingling	L	R	Prior Leg Ulcer	L	R
Heaviness	L	R	Worsening Leg Veins	L	R
Fatigue	L	R	Bulging Leg Veins	L	R
Pain	L	R	Prior Phlebitis (localized vein tenderness)	L	R
Discomfort	L	R	Thrombophilia (blood clotting disorder)	L	R
Cramping	L	R	Ruptured or Bleeding Veins	L	R
Blood Clots	L	R	Deep Vein Thrombosis (DVT)	L	R
Ankle Swelling	L	R	Restlessness in the Leg(s)	L	R

Do you have a family history of vein disease? Yes (If yes, who_____) No
Any family history of blood clots? Yes (If yes, who_____) No

Have you ever smoked tobacco? Yes No Have you ever had a substance abuse problem? Yes No

Are you currently working? Yes No What is your occupation: _____

Are you required to sit/stand for prolonged periods? Yes No Do you walk during your job? Yes No

When did you first become aware that you had a vein problem? _____

If you have worn compression stockings before, please indicate for how many months or years? _____

What relieves your vein symptoms?_____ Don't know

What makes your vein symptoms worse?_____ Don't know

Have you been previously evaluated for a vein problem? Yes No Explain:_____

Indicate which prior vein treatments you have had: (place L and/or R in space to indicate leg for all that apply)

_____ no prior vein treatments _____sclerotherapy injections _____surgical ligation

_____surgical vein stripping _____ambulatory phlebectomy _____surface laser/light

_____endovenous laser ablate _____VNUS radiofrequency closure Other:_____

VEIN HEALTH & HISTORY FORM

List your current medications:_____

Do you have any medication allergies? Yes No Explain:_____

Do you have a latex allergy? Yes No Explain:_____

List prior surgeries:_____

List prior hospitalizations:_____

List medical conditions you are being treated for:_____

Indicate which of the following conditions below which you have had (check those that apply): _____None

_____blood clotting disorder	_____anemia or bleeding disorder	_____heart defect or PFO
_____migraine headache	_____high blood pressure	_____heart murmur
_____asthma or lung disease	_____stroke or CVA	_____diabetes mellitus
_____coronary artery disease	_____peripheral artery disease	_____renal or kidney disease
_____hepatitis or liver disease	_____joint replacement surgery	_____cancer or malignancy
_____HIV/AIDS	_____hypercholestrolemia	_____other:_____

For Women Only

Number of pregnancies:_____ Number of children:_____ Ages of children:_____

Number of miscarriages:_____ Are you pregnant or planning to get pregnant? Yes No

Any pelvic area varicose veins? Yes No Do you commonly experience pain with intercourse? Yes No

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Patient Printed Name: _____ Date Signed: _____ / _____ / _____

Patient Signature: _____

_____	_____	_____	_____
RVT Signature	Date	Physician Signature	Date