LIVING WATER
VEIN INSTITUTE
& MEDICAL SPA

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

BIRTHDATE: _____ **AGE:** _____ **EMAIL:** _____

CHIEF COMPLAINT/REASON FOR VISIT: _____

DATE OF FIRST SYMPTOMS: _____ **DESCRIBE SYMPTOMS:** _____

PRIOR VEIN PROCEDURES? _____ **Where?** _____

FAMILY HISTORY OF VARICOSE VEINS (IF SO WHICH FAMILY MEMBER): _____

MEDICATIONS- INCLUDE DOSAGE	**ALLERGIES- INCLUDE REACTION**
_____	**LATEX ALLERGY: YES OR NO**_____
_____	_____
_____	_____
_____	_____

OVER THE COUNTER MEDICATIONS / SUPPLEMENTS:

ASPIRIN DAILY: YES OR NO **PLAVIX: YES OR NO** **OTHER:** _____

HEART DISEASE: **ATRIAL FILBRILLATION** **CAD** **STENTS:**_____

HISTORY OF MI/HEART ATTACK: _____**WHEN:**_____

OTHER CARDIAC CONDITIONS? _____

DVT /BLOOD CLOT: _____ **WHEN:** _____

DO YOU SMOKE: YES OR NO # PACKS PER DAY: _____ **YEARS:** _____ **DATE QUIT:** _____

ALCOHOL USE: YES OR NO / OCCASIONALLY OR DAILY (PLEASE CIRCLE ONE) **HEIGHT:** _____ **WEIGHT:** _____

EMPLOYED: YES OR NO RETIRED JOB: _____ **YEARS:** _____

PREVIOUS SURGERIES & HOSPITALIZATIONS:

_____

_____

ARTHRITIS: YES OR NO	**ASTHMA: YES OR NO**
CANCER: YES OR NO	**HYPERTENSION: YES OR NO**
DIABETES: YES OR NO	**DEPRESSION/ANXIETY: YES OR NO**
STROKE: YES OR NO	**COPD: YES OR NO**

CHILDREN: YES OR NO HOW MANY? _____

EMERGENCY CONTACT: _____

NAME **PHONE** **RELATIONSHIP**

PRIMARY CARE PHYSICIAN: _____**PHONE:**_____

****HOW DID YOU HEAR ABOUT US?****

DOCTOR SOCIAL MEDIA TV FRIEND MAGAZINE OTHER