LIVING WATER
VEIN INSTITUTE
& MEDICAL SPA

PATIENT INFORMATION

TODAY'S DATE: _____

Full Name:	Phone Number:
Date of Birth:	Email:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Emergency Contact Name: Relation:	
Emergency Contact Phone #:	
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired	
Occupation: Years Worked:	

MEDICAL HISTORY

- Have you ever had a heart attack? ☐ Yes ☐ No When: _____
- Do you have any other cardiac conditions? (Please specify) _____
  ☐ Heart disease ☐ A-Fib ☐ CAD ☐ Stents ☐ High Blood Pressure
- Have you ever had a DVT/Blood Clot? ☐ Yes ☐ No When: _____
- Do you take a blood thinner? ☐ Aspirin ☐ Eliquis ☐ Plavix Other: _____
- Do you smoke? ☐ Yes ☐ No # Packs per day: _____ Years Smoked: _____ Year Quit: _____
- Alcohol Use: ☐ Daily ☐ Occasionally ☐ Never
- Height: _____ Weight: _____
- Have you had any major surgeries? ☐ Yes ☐ No (If yes, please specify)

  _____
- Please list any allergies you have, including reaction:

  _____

  _____
- Number of pregnancies? (if applicable) _____
- Do you have any of the following medical conditions:

☐ Hypertension	☐ Stroke
☐ Depression	☐ COPD
☐ Arthritis	☐ Restless Legs
☐ Diabetes	☐ Neuropathy
☐ Anxiety	☐ Hypothyroidism
☐ Asthma	☐ Arterial Disease
☐ Cancer	☐ Lymphedema

See Back →

- Please list any medications you take, including dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

REASON FOR TODAY'S VISIT

- Chief Complaint/Reason for Visit: _____
- Symptoms/Concerns: _____
- Date symptoms began: _____
- Previous Vein Treatments (if any): _____
- Do you have a family history of varicose veins (If so, which family member?)

  _____
- Have you ever worn compression hose? ☐ Yes ☐ No
- Primary Care Doctor _____
- How did you hear about us?

  ☐ Doctor (please specify) _____

  ☐ Google ☐ Facebook ☐ TV ☐ Friend ☐ Website ☐ Patient