THE VENOUS INSTITUTE OF BUFFALO, INC

Michael A. Vasquez, MD, FACS, RVT

www.VenousInstitute.com

Welcome to The Venous Institute of Buffalo! In order to expedite the Registration process, please complete the enclosed forms and bring them with you to your appointment.

In addition, please make sure to have the following with you at the time of your appointment:

Insurance Card
Photo ID
Referral (if required by your insurance)
Copay/Deductible – due at check-in

***All High Deductible plan members are required to provide a $150 deposit at their initial visit. After insurance processes your claim, you will be billed for the remainder of your out of pocket responsibility, according to the terms of your contract

We accept all forms of payment, including all major credit cards, and CareCredit

Please arrive 15 minutes prior to your scheduled appointment.

Please enter our parking lot from Main Street.

All consultation visits are performed by one of our Licensed Physician Assistants. You will also have a comprehensive ultrasound, and can expect your initial appointment should take approximately 90 minutes.

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PATIENT INFORMATION

(PLEASE PRINT)

Patient Name: _____ Patient SSN#: _____

Patient's Date of Birth: _____/ _____/ _____ Age: _____ Marital Status: _____

Sex: MALE FEMALE Street Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____)_____ Email: _____

Patient's Employer: _____ Occupation: _____

Patient Insurance Type: _____

Name of Primary Doctor: _____

Name of Alternate/ Referring Doctor: _____

(FILL OUT THIS SECTION IF MARRIED)

Spouse Name: _____ Date of Birth: _____

Address: _____ SSN #: _____

Spouse's Employer: _____ Occupation: _____

Work Phone Number (_____) _____ Alternate Number (_____) _____

Pharmacy Name & Address: _____

_____

Case of Emergency Person: _____

Relationship: _____ Phone # (_____) _____

I authorize the use of this form on all of my insurance submission.
I authorize release of information to all of my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
I authorize payment directly made to my doctor.
I permit a copy of this authorization to be used in place of this original.

Patient Signature: _____ Date: _____

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Patient's Stats

Patient's NAME _____ DOB Date

AGE _____ WEIGHT _____ HEIGHT _____

MARITAL STATUS ☐ Single ☐ Married ☐ Other _____

ALCOHOL USE ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

TOBACCO USE ☐ Never ☐ Previous, *have quit on* ☐ Current Smoker/PPD

DRUG USE ☐ Never ☐ Current User, *type/frequency* _____

Person who referred you _____

Family Medical History

	AGE	DISEASES	*If Deceased, cause of death*
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____

Health History

Please answer the following questions in regards to your venous history.

Are you experiencing leg vein symptoms? ☐ YES ☐ NO

If yes, for how long? _____

How long have you had varicose veins or spider veins? _____

Were your leg veins and/or symptoms present during pregnancy? ☐ YES ☐ NO

If yes, number of pregnancies? _____

Do you have any family history of varicose veins, ulcers or clotting disorder? ☐ YES ☐ NO

Have you had any previous leg vein procedures or surgeries? ☐ YES ☐ NO

If yes, please explain.

Do you have a history of clotting disorder, phlebitis, bleeding from the vein? ☐ YES ☐ NO

If yes, please explain.

Have you ever had any testing done for clotting disorder? ☐ YES ☐ NO

Have you had an ultrasound or Doppler prior to your visit today? ☐ YES ☐ NO

Are you currently on hormone replacement therapy or birth control? ☐ YES ☐ NO

Have you worn prescription strength compression stockings? ☐ YES ☐ NO

If yes, how long were they worn? _____

Did wearing compression stockings reduce your leg symptoms? ☐ YES ☐ NO

Have you had any major leg injury or surgery? ☐ YES ☐ NO

Do you take medication on a regular basis for your leg symptoms? ☐ YES ☐ NO

(i.e. Tylenol, Ibuprofen)

Do you exercise regularly? ☐ YES ☐ NO

Have you had leg sores, ulcers or open wounds? ☐ YES ☐ NO

During the past week, how much of the time have you had the following leg problems?
Please check one box in each cloumn for each leg

	Heavy Legs		Aching Legs		Swelling		Night Cramps		Heat or Burning Sensation		Restless Legs		Throbbing		Itching		Tingling Sensation	
	Right	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*	*Right*	*Left*
ALL of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MOST of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GOOD BIT of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SOME of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LITTLE of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NONE of the time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How much leg pain have you had during the past week?
Please check one for each leg

	VERY SEVERE	SEVERE	MODERATE	MILD	VERY MILD	NONE
Right Leg	☐	☐	☐	☐	☐	☐
Left Leg	☐	☐	☐	☐	☐	☐

Compared to one year ago, how is your leg problem now?
Please check one for each leg

	MUCH WORSE	SOMEWHAT WORSE	ABOUT THE SAME	SOMEWHAT BETTER	MUCH BETTER	NO PROBLEM 1-YEAR AGO
Right Leg	☐	☐	☐	☐	☐	☐
Left Leg	☐	☐	☐	☐	☐	☐

Please check all that apply in each section

What factors make your symptoms WORSE

- ☐ Prolonged Standing
- ☐ Prolonged Sitting
- ☐ Prolonged Walking
- ☐ Extreme Temperature Changes
- ☐ Hormonal Changes
- ☐ Exercise
- ☐ Nothing

What factors make your symptoms BETTER

- ☐ Elevating Legs
- ☐ Rest/Sleep
- ☐ Rubbing/Massage
- ☐ Compression Stockings
- ☐ Exercise/stretching
- ☐ Changing Positions
- ☐ Nothing

Daily activities that are affected by your leg vein symptoms

- ☐ Climbing Stairs
- ☐ Exercising
- ☐ Yard Work
- ☐ Short Walks
- ☐ Long Walks
- ☐ Bathing
- ☐ Car Trips (>2 Hours)
- ☐ Household Chores
- ☐ Bending/Kneeling
- ☐ Dressing

Please check if you CURRENTLY have any of the following symptons

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

EYES
- ☐ Vision Loss in One Eye

EARS/NOSE/THROAT
- ☐ Nose Bleeds

CARDIOVASCULAR
- ☐ Difficulty Breathing at Night
- ☐ Chest Pain or Discomfort
- ☐ Racing/Skipping Heartbeat
- ☐ Shortness of Breath With Exertion
- ☐ Palpitations
- ☐ Difficulty Breathing Lying Down
- ☐ Leg Cramps With Exertion
- ☐ Weight Gain

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Coughing Up Blood
- ☐ Chest Discomfort
- ☐ Wheezing

GENITOURINARY
- ☐ Blood in Urine
- ☐ Pelvic Pain

GASTROINTESTINAL
- ☐ Vomiting Blood
- ☐ Nausea
- ☐ Vomiting
- ☐ Yellow Skin Color
- ☐ Dark, Tarry Stools
- ☐ Blood in The Stools

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Swelling

DERMATOLOGICAL
- ☐ Suspicious Lesions
- ☐ Dryness
- ☐ Poor Wound Healing
- ☐ Itching
- ☐ Changes in Skin Color
- ☐ Rash

NEUROLOGICAL
- ☐ Headaches

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression

HEMATOLOGY
- ☐ Abnormal Bleeding
- ☐ Abnormal Bruising

OTHER(s)
- ☐

Please check all medical conditions that apply to you

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ A-Fib
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Breast Disease
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Factor V
- ☐ Gerd
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis B/C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Miscarriage
- ☐ Peptic Ulcer
- ☐ Spider Veins
- ☐ Thyroid Disease
- ☐ Varicose Veins

Please list all
Medications/Dosages (including non-prescription)

or check
☐ NONE

Please list all
Allergies to Medications and/or Food

or check
☐ NONE

Please list any other
Medical Problems

or check
☐ NONE

Please list any
Previous Surgeries & Dates *(if known)*

or check
☐ NONE

Signature of PATIENT _____ Date