PATIENT REGISTRATION

NAME_____

LAST FIRST MI

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

SS#_____DOB_____AGE_____GENDER MALE FEMALE

MARITAL STATUS: _____SINGLE _____MARRIED _____WIDOWED _____DIVORCED

HOME PHONE_____CELL PHONE_____EMAIL_____

PLACE OF EMPLOYMENT_____ WORK PHONE_____

PATIENT WORKS AS _____RETIRED ☐

SPOUSE'S NAME/EMERGENCY CONTACT_____PHONE_____

SPOUSE'S EMPLOYER_____WORK PHONE_____

REFERRAL SOURCE _____PHYSICIAN(Name)_____

_____FAMILY MEMBER _____NEWSPAPER _____OTHER

_____BILLBOARD _____ANOTHER PATIENT

_____PHONE BOOK _____WEBSITE

Patient's Chief Complaint_____

INSURANCE

INSURANCE _____

ID#_____GROUP_____

POLICY HOLDER'S NAME_____

POLICYHOLDER'S DATE OF BIRTH_____SS#_____

AUTHORIZATIONS

I hereby authorize Dr. Critchlow to furnish information to insurance carriers and referred physicians concerning my illness and treatment

_____ _____

Signature of patient Date

I hereby authorize my insurance benefits to be paid directly to J. Thomas Critchlow, MD. I understand I am financially responsible for all charges.

_____ _____

Signature of patient Date

MEDICAL HISTORY

Do your legs/veins:

Ache/Pain	☐ R L	Feel Heavy	☐ R L
Swell	☐ R L	Throb	☐ R L
Itch/Burn/Stinging	☐ R L	Feel Tired/Fatigued	☐ R L
Cause cramping	☐ R L	Have discolorization	☐ R L
Become Red	☐ R L	Have a change in skin texture	☐ R L

How long have you had these symptoms?_____weeks/months/years

An injury to leg that required an operation or casting?	☐ R L	when_____
A blood clot (DVT)	☐ R L	when_____
Phlebitis (superficial blood clot)	☐ R L	when_____
Venous Stasis Ulcer (leg)	☐ R L	when_____
Hemorrhage from a varicose vein	☐ R L	when_____
Sclerotherapy	☐ R L	when_____
Vein Stripping	☐ R L	when_____
Prior laser or RF closure	☐ R L	when_____

Patient has tried the following methods to relieve symptoms:

☐ wear compressive stockings - 20-40 mmHg # of childbirths _____

☐ limit activities ☐ lose weight _____lbs ☐ exercise

☐ take time off work ☐ elevate legs ☐ take oral analgesics

☐ take pain medication

I have tried these alternate treatments for _____weeks/months/years (circle one)

Please indicate if you have any of the following conditions:

☐ Diabetes	☐ Seizures	☐ Heart Disease
☐ Renal Failure	☐ Lung Disease	☐ Hepatitis
☐ Hypertension	☐ HIV Infection	☐ Arthritis
☐ Fainting	☐ Cancer	☐ Clotting disorder

☐ Tobacco Use–how long have you used tobacco_____months/years(circle one)

Current Medication

- ☐ Coumadin
- ☐ Plavix
- ☐ Daily Aspirin
- ☐ Topical Skin Medications
- ☐ Antibiotics
- ☐ Steroids

For Women Only

- ☐ Pregnant or think you might be
- ☐ Currently Nursing(breast feeding)
- ☐ Do you think you will have more children
- ☐ Taking Oral Contraceptives
- ☐ On Hormone Replacement Therapy (HRT)
- ☐ Do you anticipate starting HRT soon?

Please list all medications that you take at least three times per week:

_____

_____

_____

Please list any and all allergies:

_____

Family History: Please indicate if any of the following conditions were present in your immediate family members:

- ☐ Varicose Veins
- ☐ Venous Ulcers
- ☐ Deep Vein Thrombosis
- ☐ Phlebitis
- ☐ A history of Vein Surgery
- ☐ Blood Clots
- ☐ Cancer

Past Surgical History – please list any surgeries or hospitalizations that you have had and when:

_____

_____

Are you presently seeing another physician for anything not listed above?

Physician's Name_____

Conditions for which you are being treated_____

Review of Systems

Constitutional:

- ☐ Fevers
- ☐ Chills
- ☐ Unexplained loss of appetite
- ☐ Unexplained loss of weight

Eyes:

- ☐ Recent unexplained change in visual acuity
- ☐ Spells of blurred vision
- ☐ Frequent headaches
- ☐ Double vision
- ☐ Glaucoma
- ☐ Other eye problems_____
- ☐ Excessive tearing or crusting
- ☐ Cataracts

ENT:

- ☐ Recent change in hearing ability
- ☐ Dizziness
- ☐ Difficulty swallowing
- ☐ Sinus problems
- ☐ Discharge from nose
- ☐ Ear problems
- ☐ Enlarged glands
- ☐ Recurrent sore throat
- ☐ Persistent Hoarseness
- ☐ Thyroid problems

Cardiac:

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ History of heart attack or disease
- ☐ History of blood clots in legs
- ☐ History of stroke
- ☐ Waking from sleep breathless
- ☐ Cardiac medications
- ☐ Pain in legs, feet, hips relieved by rest

Respiratory:

- ☐ Shortness of breath
- ☐ Cough up blood
- ☐ Bronchitis
- ☐ Cough up mucous
- ☐ Pain with breathing
- ☐ Asthma
- ☐ chronic cough
- ☐ Emphysema
- ☐ Chest pain

Gastrointestinal:

- ☐ Change in bowel habits
- ☐ Black, red or bloody stools
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Gallbladder disease
- ☐ Colon/bowel disease
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Jaundice
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Anemia
- ☐ Frequent constipation or diarrhea
- ☐ Recent weight loss/gain

Genitourinary:

- ☐ Urinary Incontinence
- ☐ Frequent urination
- ☐ Urgent or painful urination
- ☐ Waking at night to urinate
- ☐ Loss of urine with coughing/straining
- ☐ Difficulty starting to urinate
- ☐ Bladder or kidney infections
- ☐ Renal disease
- ☐ Blood in urine

Musculoskeletal:

- ☐ Change in walking ability or strength
- ☐ Painful joints
- ☐ Back or neck pain
- ☐ Arthritis
- ☐ Broken bones

Skin:

- ☐ Problematic rashes or itching
- ☐ Changes in skin color
- ☐ Ulcers or sores on feet or legs

Neurological:

- ☐ Unexplained numbness
- ☐ Tingling around mouth
- ☐ Blurred vision in one eye
- ☐ Loss of memory or movement
- ☐ Blurred speech
- ☐ History of temporary loss of strength

Psychiatric:

- ☐ Suicidal thoughts
- ☐ Hallucinations