VEIN CLINIC OF NORTH CAROLINA

3318 HEALY DR.

WINSTON SALEM, NC 27103

PH. 336-768-3530 FAX- 768-1329

Scott W. Baker, MD

Patient Instructions

1. *Bring a list of all regular medications and dosages.*
2. *Bring your insurance card and all necessary referrals.*
3. *Bring a pair of shorts.*
4. *Do not apply any lotions, creams, or oils after your last bath/shower prior to your appointment.*
5. *Please call to confirm your appointment within 24 hours of your appointment date and time. A $25 fee will be charged to all that do not show or fail to cancel the appointment.*
6. *Be Prepared as this visit could take between 1-1/2 hours to 2 hours.*
7. *Please arrive 30 minutes prior to your appointment time.*
8. *PLEASE MAIL BACK IN ENCLOSED ENVELOPE*

Patient Name: ____

Appointment Date: ____

Appointment Time: ____

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NAME: ______________________________

ADDRESS: ______________________ CITY: ______________ ST: ________ ZIP: ______

DOB: __________ AGE: __________ SS #: ______________

RACE: ______________ ETHNICITY: ______________

EMAIL: ______________________ HOME PHONE: ______________

CELL PHONE: __________ FAX: __________ WORK PHONE: ______________

XEP E"uvchh'o c{ "eqo o wpkecvg"y kj "o g"cdqwv'o {"o gfkecn'cpf "dknkpi "kphqto cvkqp"d{"ej gemkpi "gcej "vj cv'cr r n{<"J qo g"r j qpg<"aa"
EgmlO qdkng<" aa"Go ckn<"aa"Hcz<"aa"J qo g"Cf f tguu<"aa"Qvj gt*r ngcug"ur gekh{+<"aaaaaaaaaaaaa""""

EMPLOYER: ______________________ OCCUPATION: ______________

EMERGENCY CONTACT NAME: ______________________

RELATIONSHIP: ______________________ PHONE: ______________

PRIMARY PHYSICIAN (doctor you see for routine health problems or GYN): ______________

ADDRESS/PHONE NUMBER: ______________________________

REFERRING PHYSICIAN: ______________________________

ADDRESS/PHONE NUMBER: ______________________________

TO WHOM DO WE THANK FOR YOUR REFERRAL (if not physician): ______________

PRIMARY INSURANCE:

COMPANY: ______________________________

SUBSCRIBER: ______________________________

GROUP NUMBER: ______________________________

ADDRESS: ______________________________

POLICY HOLDER NAME AND DOB: (if different from patient)

NAME: ______________________________

DOB: ______________________________

SECONDARY INSURANCE:

COMPANY: ______________________________

SUBSCRIBER: ______________________________

GROUP NUMBER: ______________________________

ADDRESS: ______________________________

POLICY HOLDER NAME AND DOB: (if different from patient)

NAME: ______________________________

DOB: ______________________________

SIGNATURE OF RESPONSIBLE PARTY: ______________________ DATE: __________

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HISTORY OF LEG PROBLEMS:

Do you experience any of the following with your legs?

Aching/pain	YES	NO
Tiredness/fatigue	YES	NO
Itching/burning	YES	NO
Swelling	YES	NO
Cramping	YES	NO
Throbbing	YES	NO
Easy bruising	YES	NO
Leg restlessness	YES	NO
Bleeding	YES	NO

Total Pregnancies: ________ Vaginal deliveries #: ________ C-Sections #: _____ Miscarriages #: ________

Do you exercise regularly? YES NO

If yes, what type and frequency: ____

Are symptoms worse with: (circle all that apply)

standing sitting night time heat pre-menstrual walking/exercising

Are symptoms better with: (circle all that apply)

elevation warm soaks coolness elastic compression exercising/walking

Medication: (for leg symptoms) ____

I am able to walk a mile without symptoms? YES NO

If no, list symptoms that limit your walking: ________________________________

1. Have you been evaluated for vein problems? YES NO

If yes, please list where and when: ________________________________

2. Have you ever had vein surgery, vein injections, or laser vein treatment? YES NO

If yes, please list where and when: ________________________________

3. Were you ever prescribed surgical compression stockings? YES NO

If yes, please list the prescribing physician: ________________________________

4. Have you ever had blood clots in your legs? YES NO

If yes, please list which leg and when: ________________________________

5. Were you treated with blood thinners? YES NO

6. Have you ever had phlebitis? (inflammation of the vein, red painful area)? YES NO

If yes, please list which leg and when: ________________________________

elevation warm soaks coolness elastic compression exercising/walking

Medication (for leg symptoms): ________________________________

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MEDICATIONS: DOSE AND FREQUENCY:

1	9
2	10
3	11
4	12
5	13
6	14
7	15
8	16

ALLERGIES: (medication, latex, food, tape- reaction to each):

1	REACTION:	
2	REACTION:	
3	REACTION:	
4	REACTION:	
5	REACTION:	
6	REACTION:	
7	REACTION:	

HEIGHT: ______________________________ WEIGHT: ____________________

MEDICAL HISTORY:

Do you have heart disease: YES NO

Heart attack irregular heart beat pacemaker defibrillator murmur/mitral valve prolapse/regurgitation

Lung disease: YES NO

Asthma Emphysema COPD Oxygen: How often and liters: _________________

Sleep apnea: C-PAP: _____________ YES NO

High blood pressure: YES NO

Thyroid: YES NO

Arthritis: What areas :___________________________ YES NO

Rash: What and where: __________________________ YES NO

Diabetes: What age: ________ YES NO

Back pain: upper mid lower YES NO

GI-GERD, Hernia, Reflux: YES NO

Cholesterol: YES NO

Fibromyalgia: Where: ____

Liver/Hepatitis: What year? What type hepatitis?: ____

Cancer: Where/type/year/treatment: ____

Bladder/ prostate: ____

Other: ____

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SURGICAL HISTORY: ____

____

REVIEW OF SYSTEMS:
Do you have:
Fever: _____ **Chills:** ____ **Unintentional weight loss:** ____
Blurred vision: ____ **Decrease in hearing:** ____ **Chest pain:** ____ **Shortness of breath:** ____
Abdominal pain: ____ **Nausea:** ____ **Vomiting:** ____ **Frequent urination:** ____
Joint pain: ____ **Fatigue:** ____ **Rash:** ____ **Dizziness:** ____ **Excessive sweating:** ____

FAMILY HISTORY:
Father: Alive/deceased: Age: ___ **Deceased from:**______________________________
Health: _____________ **Varicose veins:** _________________ **Phlebitis/blood clots;** ______________

Mother: Alive/deceased: Age: ___ **Deceased from:**______________________________
Health: _____________ **Varicose veins:** _________________ **Phlebitis/blood clots;** ______________

Brother(s): Alive/deceased: Age(s): _______ **Deceased from:**______________________________
Health: _____________ **Varicose veins:** _________________ **Phlebitis/blood clots;** ______________

Sister(s): Alive/deceased: Age(s) : _______ **Deceased from:**______________________________
Health: _____________ **Varicose veins:** _________________ **Phlebitis/blood clots;** ______________

Children: Alive/deceased: Age(s): ________ **Deceased from:**______________________________
Health: _____________ **Varicose veins:** _________________ **Phlebitis/blood clots;** ______________

Other family health problems: ____

SOCIAL HISTORY:
Married: How long: ___________ **Single:** **Divorced:** **Life Partner:**
Widow(er): ____ **Do you live alone:** _____ **Family member:** ________ **Assisted living:** ______
Retirement home: _____
Previous smoker: ____ **Quit:** _____ **Smoker: How much:**_____ **How long:** ______ **Tobacco:** _________
Alcohol: _____________ **Illegal drugs:** ____________________________

PATIENT SIGNATURE: ______________________________________ **DATE:** __________

SCOTT BAKER MD: ______________________________________ **DATE:** __________