GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

Patient Registration Form

Name: _____ Today's Date: _____
FIRST MIDDLE LAST

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____ Cell Phone: ( ) _____
Email: _____
Referred by: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____ Cell Phone: ( ) _____
Email: _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about Georgia Vascular Institute? _____
Can we mail information to your home? ☐ Yes ☐ No
Can we leave a message for you at home? ☐ Yes ☐ No
Can we leave a message for you at work? ☐ Yes ☐ No
Can we send email to the address you provided? ☐ Yes ☐ No

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Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Name: _____ Age: _____ Date of Birth: _____
You were referred by: _____ Today's Date: _____
The reason why you are here today: _____

PAST MEDICAL HISTORY Check all that apply.

Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Emphysema/COPD	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Heart Problem	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Heart Attack/MI	☐ Yes ☐ No	Aneurysm	☐ Yes ☐ No
Heart Failure/CHF	☐ Yes ☐ No	Blood Clot/DVT	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No

Other: _____

PAST SURGICAL HISTORY Check all that apply and fill in the date (month and year).

☐ Heart bypass	_____	☐ Aortic aneurysm	_____
☐ Leg bypass R/L	_____	☐ Brain aneurysm	_____
☐ Vein surgery R/L	_____	☐ Gallbladder	_____
☐ Carotid surgery R/L	_____	☐ Thyroid	_____
☐ Angioplasty	_____	☐ Gastric bypass	_____
☐ Appendix	_____	☐ Hernia repair	_____

Other: _____

FAMILY MEDICAL HISTORY

	Father	Mother	Sibling
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Hypertension	☐	☐	☐
Heart problems	☐	☐	☐
Aneurysm	☐	☐	☐
Stroke	☐	☐	☐
Varicose veins	☐	☐	☐

SOCIAL HISTORY

Alcohol	☐ Yes ☐ No	If yes, how much	_____
Tobacco/Smoking	☐ Yes ☐ No	If yes, packs/day	_____
		If you quit, when	_____
Drugs	☐ Yes ☐ No	If yes, type frequency	_____
Do you live alone?	☐ Yes ☐ No		
Currently working?	☐ Yes ☐ No	If yes, type	_____

MEDICATIONS Please list all the medications you are currently taking and dosages (Use additional separate medication list sheet if needed)

_____

_____

_____

ALLERGIES _____

REVIEW OF SYSTEMS Please check all that apply.

Constitutional

Fever	☐ Yes ☐ No
Chills	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No
	lbs _____
Weight gain	☐ Yes ☐ No
	lbs _____
Fatigue	☐ Yes ☐ No
Headaches	☐ Yes ☐ No

Skin

Ulcers	☐ Yes ☐ No
Rash	☐ Yes ☐ No
Itching	☐ Yes ☐ No
Changes in color	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No
Breast discharge	☐ Yes ☐ No

Eyes

Glasses or contacts	☐ Yes ☐ No
Blurred vision	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No

ENT

Hearing loss	☐ Yes ☐ No
Earache or drainage	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No
Nose bleeds	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No
Swollen neck glands	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No

Cardiovascular

Chest pain at rest	☐ Yes	☐ No
Chest pain with exertion	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Leg or ankle swelling	☐ Yes	☐ No

Respiratory

Short of breath-rest	☐ Yes	☐ No
Short of breath-walking	☐ Yes	☐ No
Wheezing or asthma	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No

Gastrointestinal

Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Prostate problems	☐ Yes	☐ No

Musculoskeletal

Joint pain	☐ Yes	☐ No
Joint swelling	☐ Yes	☐ No
Muscle pain/cramps	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Pain legs/calf	☐ Yes	☐ No
Cold extremities	☐ Yes	☐ No

Neurologic

Dizziness/lightheaded	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Weakness	☐ Yes	☐ No

Psychiatric

Memory loss/confusion	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Heat/cold tolerance	☐ Yes	☐ No
Hormone problems	☐ Yes	☐ No

Hematologic/Immune

Easy bruising/bleeding	☐ Yes	☐ No
Slow to heal after cuts	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hepatitis A,B,C	☐ Yes	☐ No
Clotting disorder	☐ Yes	☐ No

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Venous Health History Form

Patient Name: _____ Date of birth: _____

Chief complaint: _____

DIRECTIONS: Please answer the following questions. Provide estimates for date of occurrence.

PAST MEDICAL HISTORY

1. Have you ever had vein stripping surgery? ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, when and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

FAMILY HISTORY

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

1. Do you experience any of the following in your legs?

Aching/Pain?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Heaviness?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Tiredness/Fatigue?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Itching/Burning?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Swollen ankles?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Leg cramps?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Restless legs?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs
Throbbing?	☐ Yes	☐ No	☐ Rt Leg	☐ Lt Leg	☐ Both Legs

Other? _____

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____

3. Do you take any medication for pain? (i.e. Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication do you take and how many times/mgs per day? _____

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief? _____

Venous Health History Form (cont.)

5. Do you exercise? ☐ Yes ☐ No
If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
If yes, what type and gradient? How long have you worn them? _____

_____

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed?

_____

7. Do you wear light support hose (i.e. Sheer Energy)? ☐ Yes ☐ No
If yes, do they provide relief? ☐ Yes ☐ No

8. Do you have any problem walking? ☐ Yes ☐ No
If yes, describe how it interferes with your activities of daily living. Which activities? _____

_____

9. What type of work do you do? _____
How long do you stand (hours per day) at work? _____ At home? _____
Describe how symptoms are/ if interfering with your essential job function of your specific job function, which activities: _____

_____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
If yes, when and what type of test and where on the leg? _____

_____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Name of referring Physician and how long have you been under his or her care for treatment of this condition?

_____

Patient signature: _____ Date: _____

PATIENTS: PLEASE STOP HERE. THE PHYSICIAN MAY GO OVER ADDITIONAL QUESTIONS WITH YOU.

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Medication List

Patient Name: _____ Date of birth: _____

MEDICATION	DOSAGE	FREQUENCY

PHARMACY: PHONE #:

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Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Georgia Vascular Institute to any person or organization for the purposes of carrying out treatment, obtaining payment, or conducting certain healthcare operations. I understand that further information regarding how Georgia Vascular Institute will use and disclose my information can be found in Georgia Vascular Institute's Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received Georgia Vascular Institute's Notice of Privacy Practices currently in effect.

_____

Print name of individual or personal representative

_____ _____

Signature of individual or personal representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgement because:

_____ Individual refused

_____ Emergency treatment situation

_____ Individual not able to sign due to incompetence or other medical reason

_____ Other: _____

_____ _____

Staff Signature Date