

**Laser Vein Center
Thomas Wright MD RVT**

Demographics

Patient Name: _____

Address: _____

City, St, Zip _____

Primary Phone: _____ Alternate: _____

DOB: _____ Marital Status: Married Single Other

Emergency Contact: _____ Emergency #: _____ Relationship: _____

Employer/ School _____ Occupation: _____

Which number would you prefer us to leave a message: Home ____ Cell ____ Work ____

Do we have your permission to send you a birthday card, a holiday card or perhaps a newsletter to your
Home ____ Email ____

Email: _____

Referring Source: _____

Family Doctor _____ Phone # _____

Are you currently being treated by any other physician(s)?

No Yes (*If Yes; Please list with phone number*)

List of Medications (below)	Dosage	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Pharmacy _____ Phone # _____

List ALL Allergies _____

Surgeries & Dates:

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Mark any of the following conditions you or a family member has EVER experienced?

Condition	Self	Family	Please Explain
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defibrillator/pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate/cancer enlargement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testicular cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pinched nerve	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/seizures/TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes Simplex/cold sores	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Are you pregnant? No Yes Number of Pregnancies _____ Number of Births _____

Decreased appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes
Change in weight	<input type="checkbox"/> No <input type="checkbox"/> Yes	Confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	Respiratory pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	COPD	<input type="checkbox"/> No <input type="checkbox"/> Yes
High cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Delusions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Prod. of sputum	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy bruising	<input type="checkbox"/> No <input type="checkbox"/> Yes	Coughing blood	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fevers	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Apnea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Clotting disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes
Decreased vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain in leg at rest	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pneumonia	<input type="checkbox"/> No <input type="checkbox"/>
Temporary blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Leg pain when walking	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bone/joint deformity	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blurred vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Slow healing leg wound	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Detached retina	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sensitivity to cold	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
Temporal arteritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arterial disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle aches	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	History of aneurysm	<input type="checkbox"/> No <input type="checkbox"/> Yes	Limited motion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in moles	<input type="checkbox"/> No <input type="checkbox"/> Yes	Knee replacement	<input type="checkbox"/> No <input type="checkbox"/> Yes
Seizure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Itching	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hip replacement	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spinal problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dry skin	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Migraine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chronic skin problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes w/ insulin	<input type="checkbox"/> No <input type="checkbox"/> Yes
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sore throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes -no insulin	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness in limbs	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sinus drainage	<input type="checkbox"/> No <input type="checkbox"/> Yes	Extreme appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slurred speech	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hoarseness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Extreme thirst	<input type="checkbox"/> No <input type="checkbox"/> Yes
Decreased memory	<input type="checkbox"/> No <input type="checkbox"/> Yes	Discharge from ears	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ankle swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nose bleeds	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatoid arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Atrial fibrillation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	<u>FEMALE ONLY</u>	
Labored breathing	<input type="checkbox"/> No <input type="checkbox"/> Yes	ringing in ears	<input type="checkbox"/> No <input type="checkbox"/> Yes	Irregular periods	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Painful swallowing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital heart dis.	<input type="checkbox"/> No <input type="checkbox"/> Yes	Indigestion	<input type="checkbox"/> No <input type="checkbox"/> Yes	Menopause	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic heart dis.	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last pelvic exam	_____ mo / year
Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vomiting blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last period	_____ year
Loss of consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gall bladder problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	<u>OFFICE USE ONLY</u>	
Palpitations	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver disease	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Chest pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Chest discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Unable to urinate	<input type="checkbox"/> No <input type="checkbox"/> Yes	Jaundice	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Painful urination	<input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Prostate problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Abdominal pain	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Kidney/bladder dis.	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bloody stools	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Decreased urine stream	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in stool color	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Kidney failure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in bowel habits	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Blood in urine	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Excessive urination	<input type="checkbox"/> No <input type="checkbox"/> Yes				

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Habits

Do you drink alcoholic beverages? No Yes (#/week _____)
Do you now or have you ever used tobacco? No Yes (Packs/week _____)Quit Date, if applicable _____
When was your last exposure to the Sun [include tanning booth]? _____
Do you use chemical tanning lotions? _____

Vein History

When did you first notice your enlarged or discolored veins? _____
Where are the veins you are seeking a medical opinion for located? Face Leg(s), (Circle) Right Leg / Left Leg / Both
Have you ever worn prescription grade compression stockings? No Yes, When and for how long? _____
Do you have a family history of vein problems? No Yes, What family member? _____
Please next to the symptoms that apply to you: Aching leg(s) Appearance Burning Cramps
 Dull Pain Heaviness Itching Leg Ulcers
 Restless Legs Sharp Pain Swelling Throbbing
 Tiredness Other: _____

Phlebitis (Clot in surface veins in legs)? No Yes, When _____
Deep Vein Thrombosis (Clot in deep veins)? No Yes, When _____
Pulmonary Embolus (Blood clot in lungs)? No Yes, When _____
Bleeding from veins? No Yes, When _____
Have you had sclerotherapy before? No Yes, When _____
Venogram (Vein X-Ray) No Yes, When _____
Have you ever had vein surgery? No Yes, When _____
Hemorrhoids? No Yes, When _____
IV drug use? No Yes, When _____
AIDS/HIV/hepatitis? No Yes, When _____
Trauma/injury to your legs? No Yes, When _____
Clotting disorder? No Yes, When _____

I request that payment of authorized Medicare/third party insurers benefits be made either to me or on my behalf to Dr. Thomas Wright for any services furnished by me. I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services or third party insurer or their agents any information needed to determine these benefits or benefits for related services. I understand I am responsible for any balance not covered by my insurer.

Patient Signature

Date