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: _____

VCNC staff may communicate with me about my medical and billing information by checking each that apply: Home phone: __ Cell/Mobile: __ Email: __ Fax: __ Home Address: __ Other(please specify): _____

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: PHARMACY:	
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: _____

SURGICAL HISTORY: _____

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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:** _____