Weill Cornell Medicine

Weill Cornell Vascular

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ DOB: _____ Age: _____

Phone: (H) _____ (W) _____ (C) _____ Indicate Primary: _____

Email address: _____

Religion: _____ Ethnic Group: _____ Race: _____

Have you traveled to Africa (specifically (Guinea, Liberia , Sierra Leone, and or Mali (Kayes, Kouremale, and Bamako)? ☐ Yes ☐ No

Emergency contact: _____ Relationship: _____ Phone: _____

Primary care physician: _____ Phone: _____

Address: _____

Referring physician: _____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

How did you hear about us?

☐ Referring Physician

☐ Radio ad

☐ Friend

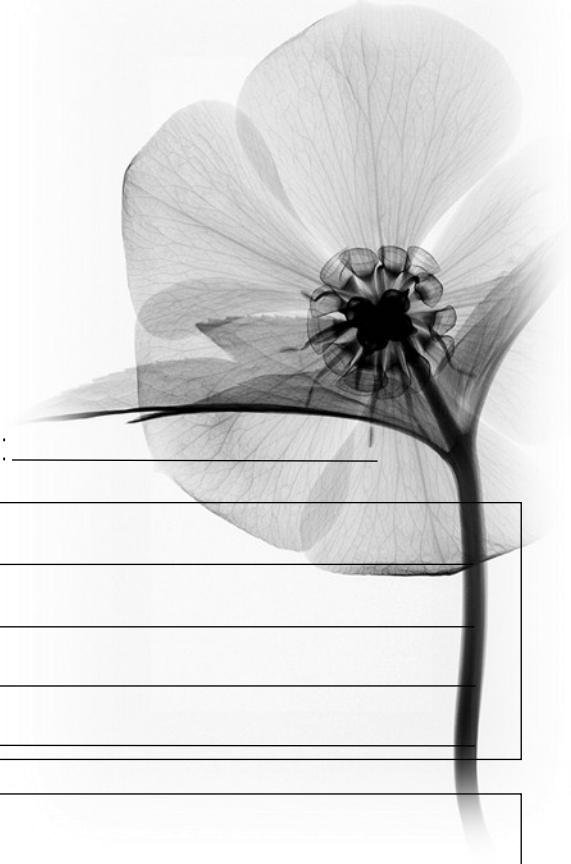
☐ Online Research: (Circle one) cornellvascular.com NYP-Cornell website Vein Directory Yelp Facebook Vitals Healthgrades

☐ Other: (Please specify) _____

_____

I hereby assign my insurance benefits to be paid directly to NYH-CUMC Radiology Group. I am financially responsible for non-covered services. I authorize the release of medical information related to the service herein.

Signature: _____ Date: _____



Weill Cornell Vascular

New Patient Medical History Form
Deep Vein Disease

Please print clearly

Name: _____ Date: _____

Briefly explain your problem: _____

_____

_____

_____

Venous History

Have you ever undergone any of the following treatments for deep vein thrombosis or post thrombotic syndrome (PTS)?

	Yes	No	Date(s) performed	Outcome
Surgery	☐	☐	_____	_____
Anti-coagulation	☐	☐	_____	_____
Other	_____			

Do you currently or have you ever worn medical support stockings for your vein problems?

☐ No ☐ Most days

☐ Intermittently ☐ Everyday

Vein Assessment :

LEFT Leg Symptoms	No or minimal	Mild	Moderate	Severe
Cramps	☐	☐	☐	☐
Itching	☐	☐	☐	☐
Pins and needles	☐	☐	☐	☐
Leg heaviness	☐	☐	☐	☐
Pain	☐	☐	☐	☐

RIGHT Leg Symptoms	No or minimal	Mild	Moderate	Severe
Cramps	☐	☐	☐	☐
Itching	☐	☐	☐	☐
Pins and needles	☐	☐	☐	☐
Leg heaviness	☐	☐	☐	☐
Pain	☐	☐	☐	☐

Social History

Current Smoking Status:

- ☐ Current everyday smoker ____ packs/day
- ☐ Current someday smoker ____ packs/day
- ☐ Former smoker ____ packs/day
  _____ stop date
- ☐ Never a smoker
- ☐ Passive smoker

Alcohol Use:

☐ Yes ☐ No

Drug Use:

☐ Yes ☐ No

Chewing Tobacco Use:

- ☐ Current User
- ☐ Past User
- ☐ Never a User

Past Medical History

Are you currently receiving or have you received treatment for any of the following medical conditions?

☐ Yes ☐ No

If yes, please detail below with year, diagnosis, and treatment given.

___ Anemia
___ Anxiety/Depression
___ Hiatal Hernia
___ Bleeding Disorder
___ Breast Cancer
___ Irritable Bowel Syndrome
___ Cataracts
___ Claudication
___ Diabetes
___ Gallstones
___ Heart Attack
___ Heart Murmur
___ Hemorrhoids
___ Hepatitis/Jaundice/Li
___ Sickle Cell/Carrier
___ Hypertension
___ Incontinence
___ Thrombophlebitis
___ Kidney Stones
___ Frequent Bladder Infections
___ Lung Disease
___ Migraines/Headaches
___ Mitral Valve Prolapse
___ Pneumonia/Bronchitis
___ Seizures/Epilepsy
___ Arthritis
___ Stroke
___ Cancer
(specify) _____
___ Thrombotic Disorder (Blood Clot)
___ Thyroid
___ Urinary Incontinence
___ Varicose/Spider Veins
___ Other

Details: _____

Past Surgical History

Type of Procedure	Date of Procedure	Reason for Procedure
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____
4)_____	_____	_____
5)_____	_____	_____
6)_____	_____	_____

Obstetrics History

Are you currently pregnant? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many children do you have? ____

Family History

Does anyone in your family have varicose or spider veins? ☐ Yes ☐ No

If so, whom? _____

Have you or has anyone in your family been diagnosed with "phlebitis" or "blood clots"?

☐ Yes ☐ No

If yes, detail year and treatment given. _____

Medications

Please list ALL medications (include prescription, over the counter and vitamins). If you are NOT taking any medications, please write NONE. Sign and date the form below after completion.

Medication	Dose/Frequency

Medication	Dose/Frequency

Allergies to Medications

Medication	Type of Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

Review of Systems

Please check any of the following that are appropriate. (If nothing is checked it is assumed negative)

Constitutional
- ☐ weight change
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ poor appetite
- ☐ fatigue
- ☐ insomnia

Eyes
- ☐ vision change
- ☐ double vision
- ☐ pain
- ☐ discharge
- ☐ dryness

Ear, Nose and Throat
- ☐ hearing loss
- ☐ ringing in the ears
- ☐ ear pain
- ☐ ear discharge
- ☐ nasal congestion
- ☐ runny nose
- ☐ post nasal drip
- ☐ nose bleeds
- ☐ mouth ulcers
- ☐ sore throat
- ☐ dysphagia

Cardiovascular
- ☐ chest pain
- ☐ palpitations
- ☐ leg swelling
- ☐ claudication
- ☐ lightheadedness
- ☐ passing out
- ☐ decreased exercise tolerance
- ☐ heart attack

Respiratory
- ☐ shortness of breath
- ☐ cough
- ☐ coughing up blood
- ☐ wheezing
- ☐ sputum production
- ☐ snoring
- ☐ apnea
- ☐ daytime drowsiness

GI
- ☐ upset stomach
- ☐ nausea
- ☐ vomiting
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ reflux
- ☐ vomiting blood
- ☐ blood in stool
- ☐ jaundice
- ☐ hepatitis

MSK
- ☐ joint aches
- ☐ muscle aches
- ☐ fractures
- ☐ bone pain

GU
- ☐ urinary frequency
- ☐ urinary urgency
- ☐ nighttime urination
- ☐ blood in urine
- ☐ pain with urination
- ☐ urinary incontinence
- ☐ urethral discharge
- ☐ genital lesions
- ☐ vaginal discharge
- ☐ vaginal bleeding

Skin
- ☐ rash
- ☐ ulcers
- ☐ hair loss
- ☐ skin changes

Neuro
- ☐ weakness
- ☐ headache
- ☐ memory loss
- ☐ convulsions
- ☐ vertigo
- ☐ tremor
- ☐ paresthesias

Endocrine
- ☐ heat intolerance
- ☐ cold intolerance
- ☐ frequent urination
- ☐ excessive thirst

Blood
- ☐ easy bleeding
- ☐ easy bruising
- ☐ enlarged lymph nodes
- ☐ anticoagulant use

Allergy/Immunology
- ☐ skin rashes
- ☐ anaphylaxis
- ☐ angioedema
- ☐ skin tightness
- ☐ morning stiffness
- ☐ Raynaud's

Psych
- ☐ depressed mood
- ☐ anxiety
- ☐ suicidal ideation
- ☐ hallucination

Additional Information

Please list any additional information that you feel is relevant

_____

_____

_____

Sign and Date Below

Please review the medications and information in this packet for accuracy and sign and date below

Patient Signature_____

Date _____

- C I V I Q -14 -

SELF-QUESTIONNAIRE PATIENTS

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday life of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent. **For each symptom, sensation or type of discomfort listed, we would like you to answer in the following way:**

Please consider whether you have experienced what is described in each sentence, and if the answer is 'yes', how **intense** it was. There are five response options. Please circle the one which best describes your situation.

Circle 1	if the symptom, sensation of discomfort described does not apply to you
Circle 2, 3, 4 or 5	if you have felt it to a greater or lesser extent

1) During the past four weeks, have you had any **pain** in your **ankles** or **legs**, and how severe has this pain been?

Circle the number that applies to you.

No pain	Slight pain	Moderate pain	Considerable pain	Severe pain
1	2	3	4	5

2) During the past four weeks, how much trouble have you had at **work** or with your **usual daily activities because of your leg problems?**

Circle the number that applies to you.

No trouble	Slight trouble	Moderate trouble	Considerable trouble	Severe trouble
1	2	3	4	5

3) During the past four weeks, have you **slept poorly** because of your leg problems, and how often?

Circle the number that applies to you.

Never	Rarely	Fairly often	Very often	Every night
1	2	3	4	5

During the past four weeks, how much **trouble** have you had **carrying out the actions and activities** listed below **because of your leg problems?**
For each statement in the table below, indicate how much trouble you have had by circling the number that applies to you.

	No trouble	Slight trouble	Moderate trouble	Considerable trouble	Could not do it
4) Climbing several flights of stairs	1	2	3	4	5
5) Crouching / Kneeling down	1	2	3	4	5
6) Walking at a brisk pace	1	2	3	4	5
7) Going out for the evening, going to a wedding, a party, a cocktail party...	1	2	3	4	5
8) Playing a sport, exerting yourself	1	2	3	4	5

Leg problems can also affect your spirits. How closely do the following statements correspond to how you have felt during the past four weeks?
For each statement in the table below, circle the number that applies to you.

	Not at all	A little	Moderately	A lot	Completely
9) I felt nervous/tense	1	2	3	4	5
10) I felt I was a burden	1	2	3	4	5
11) I felt embarrassed about showing my legs	1	2	3	4	5
12) I got irritated easily	1	2	3	4	5
13) I feel as if I was handi-capped	1	2	3	4	5
14) I did not feel like going out	1	2	3	4	5