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:

_____

_____

_____

Laser Vein Center
Thomas Wright MD RVT

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

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

Laser Vein Center
Thomas Wright MD RVT

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

Decreased appetite	☐ No ☐ Yes
Change in weight	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
High cholesterol	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Fevers	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Decreased vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Temporary blindness	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Detached retina	☐ No ☐ Yes
Temporal arteritis	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Seizure	☐ No ☐ Yes
Fainting	☐ No ☐ Yes
Headache	☐ No ☐ Yes
Migraine	☐ No ☐ Yes
Stroke	☐ No ☐ Yes
Numbness in limbs	☐ No ☐ Yes
Slurred speech	☐ No ☐ Yes
Decreased memory	☐ No ☐ Yes
Ankle swelling	☐ No ☐ Yes
Atrial fibrillation	☐ No ☐ Yes
Labored breathing	☐ No ☐ Yes
Dizziness	☐ No ☐ Yes
Congenital heart dis.	☐ No ☐ Yes
Rheumatic heart dis.	☐ No ☐ Yes
Murmur	☐ No ☐ Yes
Loss of consciousness	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes
Chest discomfort	☐ No ☐ Yes
Unable to urinate	☐ No ☐ Yes
Painful urination	☐ No ☐ Yes
Prostate problems	☐ No ☐ Yes
Kidney/bladder dis.	☐ No ☐ Yes
Decr. urine stream	☐ No ☐ Yes
Kidney failure	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Anxiety	☐ No ☐ Yes
Confusion	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Delusions	☐ No ☐ Yes
Easy bruising	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Clotting disorder	☐ No ☐ Yes
Bleeding disorder	☐ No ☐ Yes
Pain in leg at rest	☐ No ☐ Yes
Leg pain when walking	☐ No ☐ Yes
Slow healing leg wound	☐ No ☐ Yes
Sensitivity to cold	☐ No ☐ Yes
Arterial disease	☐ No ☐ Yes
History of gangrene	☐ No ☐ Yes
Change in moles	☐ No ☐ Yes
Itching	☐ No ☐ Yes
Rash	☐ No ☐ Yes
Dry skin	☐ No ☐ Yes
Chronic skin problems	☐ No ☐ Yes
Sore throat	☐ No ☐ Yes
Sinus drainage	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes
Discharge from ears	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Hearing loss	☐ No ☐ Yes
Ringing in ears	☐ No ☐ Yes
Painful swallowing	☐ No ☐ Yes
Indigestion	☐ No ☐ Yes
Vomiting	☐ No ☐ Yes
Vomiting blood	☐ No ☐ Yes
Gall bladder problems	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Jaundice	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Bloody stools	☐ No ☐ Yes
Change in stool color	☐ No ☐ Yes
Change in bowel habits	☐ No ☐ Yes

Cough	☐ No ☐ Yes
Respiratory pain	☐ No ☐ Yes
COPD	☐ No ☐ Yes
Prod. of sputum	☐ No ☐ Yes
Coughing blood	☐ No ☐ Yes
Apnea	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes
Pneumonia	☐ No ☐
Bone/joint deformity	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle aches	☐ No ☐ Yes
Limited motion	☐ No ☐ Yes
Knee replacement	☐ No ☐ Yes
Hip replacement	☐ No ☐ Yes
Spinal problems	☐ No ☐ Yes
Thyroid disorder	☐ No ☐ Yes
Diabetes w/ insulin	☐ No ☐ Yes
Diabetes -no insulin	☐ No ☐ Yes
Extreme appetite	☐ No ☐ Yes
Extreme thirst	☐ No ☐ Yes
Lupus	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes

FEMALE ONLY

Irregular periods	☐ No ☐ Yes
Breast problems	☐ No ☐ Yes
Menopause	☐ No ☐ Yes
Last pelvic exam	_____ mo / year
Last period	_____ year

OFFICE USE ONLY

Laser Vein Center
Thomas Wright MD RVT

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