

ADVANCED Vein Therapies

**46325 W 12 Mile Road
Suite 335
Novi, Michigan 48377**

**Phone: (248) 344-9110
Fax: (248) 344-9111**

PATIENT INFORMATION

Name _____ age _____ date of birth ____ / ____ / ____

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ - _____ - _____ [] male [] female

Occupation _____ _ full-time _ part-time _ retired

Home Number _____ Work Number _____ Cell Number _____

Preferred contact number (Home, work or cell) _____ E-mail _____

Marital Status [] Single [] Married * [] Divorced [] Widowed

*If Married

Spouse's Name _____ Spouse's date of birth ____ / ____ / ____

PRIMARY INSURANCE

- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of _____
- Blue Care Network *Referral* Yes / No
- Medicare
- Aetna
- PPOM *
- Other _____
- I do not have insurance

Policyholder's Name _____ Relationship _____

* For PPOM insurance, please list policyholder's social security number _____

SUPPLEMENTAL INSURANCE CARRIER _____

How did you hear about Advanced Vein Therapies? _____

If you were referred by a Doctor, please list their name and number _____

Emergency Contact Person _____

Emergency phone number _____

Name: _____

Headaches	[]	[]	Blood in Urine	[]	[]
Thyroid	[]	[]	Painful Urination	[]	[]
Seizures	[]	[]	Kidney Stones	[]	[]
CARDIAC:	Yes	No	Urinary Tract Infection	[]	[]
Stroke	[]	[]	SKIN:	Yes	No
High Blood Pressure	[]	[]	Bruise Easily	[]	[]
Heart Disease	[]	[]	Skin Infection	[]	[]
Chest Pain	[]	[]	History of Skin Cancer	[]	[]
High Cholesterol	[]	[]	Eczema	[]	[]
Cardiac Pacemaker	[]	[]	Changes in Texture	[]	[]
Heart Murmur	[]	[]	MUSCLES/EXTREMITIES:	Yes	No
Mitral Valve Prolapse	[]	[]	Fractures	[]	[]
Rheumatic Fever	[]	[]	Arthritis	[]	[]
LUNGS:	Yes	No	Artificial Joints	[]	[]
Asthma or Lung Problems	[]	[]	Tobacco Use	[]	[]
Shortness of Breath	[]	[]	Radiation Therapy	[]	[]
Pain with Respirations	[]	[]	Fibromyalgia	[]	[]
Hay Fever/Allergies	[]	[]	OTHER:	Yes	No
GASTROINTESTINAL:	Yes	No	Diabetes	[]	[]
Heartburn	[]	[]	Cancer	[]	[]
Recent Weight Loss	[]	[]	Anemia	[]	[]
Stomach Ulcers	[]	[]	HIV	[]	[]
Liver disease or hepatitis	[]	[]	Liver Disease	[]	[]
Bleeding	[]	[]	Blood clots	[]	[]
Constipation	[]	[]	Pulmonary Embolism	[]	[]
Diarrhea	[]	[]	Sleep Apnea	[]	[]

Have you ever been pregnant? **Yes** [] **No** [] If so, how many times?

Please explain "yes" answers. _____

Please list any other medical problems not listed. _____

6 Do you require antibiotics before surgical or dental procedures? **Yes** [] **No** []

7 Please list below any surgeries you have had

8 Please list all medications you are taking (incl. non-prescription, aspirin, birth control pills, vitamins)

Surgeries	Dates	Name	Dosage
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_____	2	_____
_____	3	_____
_____	4	_____
_____	5	_____
_____	6	_____
_____	7	_____

9 Are you allergic to any medications? **Yes** [] **No** []

If **Yes**, please list. _____

10 Are you allergic to Latex? **Yes** [] **No** []

11 FAMILY HISTORY

	Yes	No	Relationshi
Cancer	[]	[]	_____
Stroke	[]	[]	_____
Diabetes	[]	[]	_____
Varicose Veins	[]	[]	_____
Cardiac Disease	[]	[]	_____

12 SOCIAL HISTORY:

ALCOHOL:	Yes []	No []
If yes , how much and how often? _____		
TOBACCO:	Yes []	No []
If yes , how much and how often? _____		

13 Family Physician (name): _____ Telephone: _____

Location: _____

May we contact your family physician? **Yes** [] **No** []

SIGNATURE: _____ **DATE:** _____