VEIN CENTER
of NEW MEXICO™

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Email: _____

Marital Status: Single Married Divorced Preferred method of communication: _____

Pharmacy: _____ Pharmacy Location: _____

Referring Physician: _____ Primary Care Physician: _____

Race:
Native American
Asian
African American
Caucasian
Pacific Islander
Other: _____

Ethnicity:
Hispanic
Non-Hispanic
Decline to Answer

Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____

Insurance Information

Primary Insurance:

Insured Name: _____ Insured Date of Birth: _____

Insurance Carrier: _____ Group # _____

Patient Id# _____ Relationship to Insured: _____

Secondary Insurance:

Insured Name: _____ Insured Date of Birth: _____

Insurance Carrier: _____ Group # _____

Patient Id# _____ Relationship to Insured: _____

_____ _____

Patient Signature **Date**

VEIN CENTER of NEW MEXICO™

Michael B. Harding, MD, FACC, RPVI
Board Certified in Vascular Medicine
Board Certified in Cardiology
Board Certified in Internal Medicine

Crystal Lang, RVT
Carmen Martin, RVS

MEDICAL RECORDS RELEASE

I, _____, hereby authorize THE VEIN CENTER OF NEW MEXICO, LLC, to review and/or release copies of my medical records and all related records and reports. This is to also include any institution, organization, person or persons deemed appropriate to obtain my personal medical information.

_____
Name of Physician/Facility

_____
Address of Physician/Facility

_____
Phone # and Fax of Physician/Facility

I agree that a copy of this authorization shall be valid as the original.

Date: _____ Signed: _____

Address: _____

_____

WITNESS: _____

VEIN CENTER
of NEW MEXICO™

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

I, _____, hereby request and authorize all medical records of the above named patient be released from:

_____
Name of Physician/Facility

_____
Address of Physician/Facility

_____
Phone # of Physician Facility/Fax# of Physician Facility

Please fax all medical records to:

Vein Center of NM, LLC.
801 Encino Pl. NE, Suite C12
Albuquerque, NM 87102
Phone 505 247-4849
Fax 505 247-4850

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether negative or positive) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing. A photocopy of this authorization/consent, which contains my signature shall be considered effective and valid as the original and shall be honored as such by those to whom it is provided. By this signature I acknowledge I have received a copy of this document for my personal records.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Witness Signature Date

Waiver

I understand that Vein Center of new Mexico **does not** file for reimbursement of compression stockings with my insurance company;_____ therefore, if I choose the convenience of purchasing my stocking from the Vein Center of New Mexico, I am responsible for the full cost charged by the clinic.

Please note: There are **no refunds** or **exchanges** for compression stockings, socks, stocking applicators or garter belts.

Signature_____

Date_____

This waiver is valid for one year from the date it was signed!

VEIN CENTER
of NEW MEXICO™

Patient Billing Policy

1. Vein Center of New Mexico makes every effort to verify your insurance coverage and benefits, but it is your responsibility to be familiar with your health insurance and what it covers PRIOR to being seen by our physician. We will bill your insurance company if our facility and physician are contracted with your insurance company.
2. Please bring your current insurance identification card to each appointment. If we cannot verify your insurance, you can still be seen; however, you will need to pay in full at the time of service. If you provide our office with your insurance information within 15 days of the date of service, and if we can verify your insurance, we will then bill your insurance company for you.
3. If your insurance company requires a referral to be seen at our office, it is YOUR responsibility to obtain a referral from your primary care physician and bring it with you to your appointment. If your insurance company requires a referral and you do not bring it, your appointment will be cancelled.
4. Please be prepared to pay any co-payment, as required by your insurance company, at the time of service. We accept cash, credit cards and personal checks.
5. Please also be prepared to a portion of any deductible and/or co-insurance. Our scheduler will review amounts with you before any treatment. Should your account have a credit after the insurance has processed the claim, you will be refunded by mail.
6. Patient balances must be paid in full within 30 days of service. If you are unable to pay your account in full, our office will work with you to set up a payment plan. There will be a $5.00 rebilling fee for any month over 90 days that a payment on the account has not been paid.
7. Our practice charges $35 for any returned checks. We will only accept credit card or cash payments for any accounts that have a returned check.
8. Some treatment may be considered cosmetic and deemed not medically necessary. For these treatments, your insurance will not be billed and you will need to pay in full at time of service.
9. If you "no-show" for an appointment, or if you cancel an appointment with less than 48 hours' notice, you may be subject to a "no-show" fee and/or be discharged from this practice.
10. Vein Center of New Mexico DOES NOT file for reimbursement of compression stockings or other compression aids.

Medicare Patients

Please read and sign the statement below

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vein Center of New Mexico, LLC. For any services furnished to me by the providers in the office. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services furnished to me.

_____ _____

Patient Signature **Date**

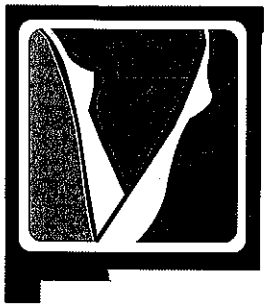
All professional services rendered are charged to the patient and the patient is financially responsible for all charges. I agree that in the event my insurance denies payment, that I am ultimately responsible for any unpaid balance on my account.

It is the patient's responsibility to provide any referrals required by your insurance company prior to your appointment. It is also the patient's responsibility to verify that we have complied with all of your insurance company's requirements regarding authorization of any testing and/or procedures recommended by any physician of Vein Center of NM, LLC.

Insurance Authorization and Assignment: I hereby authorize Vein Center of NM, LLC. To furnish information concerning my illness and treatment to any physician or hospital whose care I have been under, or whom I may be referred to for additional diagnosis or treatment, and to my insurance carrier to process claims for medical benefits for me and/or my dependents. I hereby assign to Vein Center of NM, LLC. all insurance payments for services rendered. A photocopy of this authorization may be honored. I consent to photography to be performed, if necessary, as visual data for my medical record, teaching purposes and/or marketing purposes.

_____ _____

Patient Signature **Date**



VEIN CENTER
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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Vein Center of New Mexico, LLC.'s Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Patient's Date of Birth

_____ _____

Signature of Patient or Parent/Legal Guardian Date

Provided By HCSI

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April 14, 2003
Revised September 19, 2017

Vein Center of New Mexico, LLC.
801 Encino Pl. NE, Suite C-12
505 247-4849

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Jade Hopkins – Practice Manager	505 247-4849	Jade@veincenternm.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

VEIN CENTER
of NEW MEXICO™

Detailed Directions

TRAVELING SOUTH ON I-25

Exit I-25 at Martin Luther King Blvd and turn left onto Martin Luther King Blvd. Travel beneath the freeway and immediately turn left at the first light, onto Oak Street. Travel north to Plaza Inn and turn right onto Las Lomas Place. Travel east to the stop sign at Encino, turn left, and drive ½ block north. Turn left into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.

TRAVELING NORTH ON I-25

Take the Martin Luther King Blvd exit onto Oak Street and travel straight north, through the intersection and up 1 ½ blocks, toward the Plaza Inn. Turn right onto Las Lomas Place, going uphill. Turn left at the stop sign onto Encino Place and drive ½ block north. Turn left into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.

TRAVELING WEST ON LOMAS BLVD

Just before you go under the I-25 freeway, turn left on Medical Arts Ave and drive to the top of the hill. Take a right at the stop sign onto Encino Place and drive ¼ block. Turn right into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.

TRAVELING EAST ON LOMAS BLVD

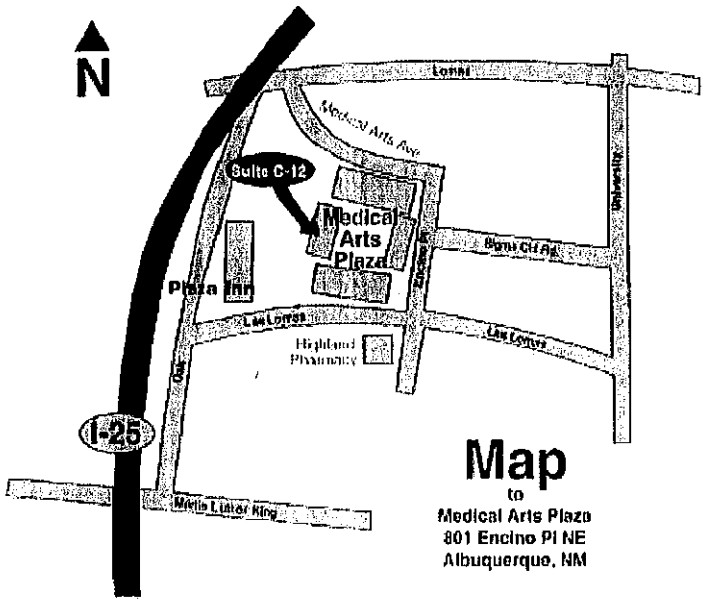
Drive under I-25 and turn right onto Medical Arts Ave. Drive to the top of the hill and take a right at the stop sign, onto Encino Place. Drive ¼ block and turn right into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.

TRAVELING SOUTH ON UNIVERSITY BLVD

After crossing Lomas Blvd, turn right onto Sigma Chi Rd and drive west for 2 blocks. At the second stop sign, drive across Encino Place directly into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.

TRAVELING NORTH ON UNIVERSITY BLVD

After crossing Central Avenue, travel past two stop lights and turn left on Las Lomas, one block past the second light. Drive west on Las Lomas. At the second stop sign, turn right and drive north on Encino Place for ½ block. Turn into the Medical Arts Square offices. We are in office C-12, near the southwest corner of the plaza.



Map
to
Medical Arts Plaza
801 Encino Pl NE
Albuquerque, NM

DATE:_____

Vein Center of New Mexico

Revised 12/09

Patient Medical History

This questionnaire is designed to facilitate our evaluation of your medical problems

NAME: AGE: Date of Birth:

Referring Physician Or Friend /Radio Ad/ Newspaper Ad/Internet/ Other

List other physicians involved in your care:

Primary Care Physician

Please circle or check positive findings

CHILDHOOD DISEASES:

Scarlet Fever ( )
Rheumatic Fever ( )
Polio ( )
Other ( )
Please list

ADULT MEDICAL DISEASES:

AIDS (HIV) ( )
Anemia ( )
Arterial Disease ( )
Arthritis(Osteoarthritis / Rheumatoid) ( )
Asthma ( )
Back Problems
Blood Problems (Bleeding/Clotting) ( )
Cancer ( )
Chronic Bronchitis ( )
Diabetes ( )
Emphysema/COPD ( )
Fibromyalgia ( )
GERD (acid reflux) ( )
Gout ( )
Heart Disease ( )
Hepatitis A/ B/ C (please circle) ( )
Hiatal Hernia ( )
High Blood Pressure ( )
High Cholestrol/Triglycerides ( )
Inflammatory Bowel Disease ( )
Irritable Bowel Syndrome ( )
Crohn's Disease ( )
Colitis ( )
Kidney Disease ( )
Liver Disease ( )
Mononucleosis ( )
Obesity- over weight ( )
Osteoporosis/Osteopenia ( )
Prostate Disease ( )
Seizures/Epilepsy ( )
Sleep Apnea ( )
Stroke ( )
Thyroid disease ( )
Tropical Disease ( )
Tuberculosis ( )
Other medical diseases not listed

MEDICATIONS: (include dosage)

Only list medications for the present and the past 6 weeks

Antacids ( )
Antibiotics ( )
Antidepressants ( )
Birth Control ( )
Blood Thinners ( )
Coumadin, Lovenox
Plavix, or Aspirin
Dosage_____ How often_____
Cortisone/ Prednisone ( )
Diabetes ( )
Digitalis ( )
Blood Pressure ( )
Potassium ( )
Thyroid ( )
Seizure Medication ( )
Water pills (diuretics) ( )
Weight control pills ( )
Other medications:

ALLERGIES:

Penicillin ( )
Sulfa ( )
X-ray dyes ( )
Iodine/Shellfish ( )
Epinephrine ( )
Hayfever / Insect Stings ( )
Any other allergies please list

PERSONAL/ SOCIAL

Single/ Married/ Divorced/ Widowed/ Partner
Tobacco: Use now or before
Packs per day:_____
How many years: _____
Cigars: Yes/ No
Alcohol Use: Yes/ No
Please list drinks per day:
Beer_____Wine_____
Liquor_____
Recreational Drugs _____
Occupation:
Current_____
Previous_____
Exercise:
Type:_____
How Often:_____

OPERATIONS: (PLEASE INCLUDE ALL OPERATIONS AND YEAR)

HOSPITALIZATIONS: (OTHER THAN SURGERY AND PLEASE INCLUDE THE YEAR)

Continued on page 2

REVIEW OF SYSTEMS

SKIN:

Tattoos
Rashes ( )
Warts ( )
Tumors, Cysts ( )
Boils ( )
Cancer ( )
Other ( )
Comments

HEAD:

Migraine headaches ( )
Frequent/ Severe headaches ( )
Seizures (fits) ( )
Loss of consciousness ( )
Loss of memory(Amnesia) ( )
History of concussion ( )
or brain injury ( )
Other ( )
Comments

EYES:

Blurring ( )
Double vision ( )
Blindness ( )
Wear glasses ( )
Near vision ( )
Far vision ( )
Glaucoma ( )
Cataracts ( )
Spots in vision ( )
Other ( )
Comments

NOSE:

Sinusitis ( )
Chronic/frequent colds ( )
Severe nosebleeds ( )
Other ( )
Comments

MOUTH:

Sore tongue ( )
Ulcers ( )
Tooth or gum problems ( )
Dentures (upper or lower) ( )
Other ( )
Comments

EAR-NOSE-THROAT

Vertigo (dizziness) ( )
Hearing loss ( )
Infections ( )
Ear aches ( )
Other ( )
Comments

NECK:

Thyroid disease ( )
Goiter ( )
Hoarseness ( )
Heat intolerance ( )
Cold intolerance ( )
Tumors ( )

RESPIRATORY:

Tuberculosis ( )
Asthma ( )
Bronchitis ( )
Coughing blood ( )
Chronic cough ( )
Soaking sweats (night) ( )
Chest pain ( )
Emphysema ( )

CARDIAC:

Heart attack ( )
Rhythm abnormalities ( )
Chest pain/ pressure/Angina ( )
Shortness of breath ( )
Can you sleep flat? Yes/ No
High blood pressure ( )
Palpitations/pounding heart ( )
Nitroglycerine use? Yes/ No
Heart murmurs ( )
Mitral valve prolapse ( )

BREASTS

Tumors ( )
Nipple bleeding/discharge ( )
Pain ( )
History of breast cancer
in your family Yes/ No
Other ( )
Comments:

G.I. (GASTROINTESTINAL):

Hepatitis ( )
Cirrhosis ( )
Jaundice (yellow skin) ( )
Recent weight loss ( )
Recent weight gain ( )
Loss of appetite ( )
Nausea ( )
Vomiting ( )

G.I. (CONT)

Frequent indigestion ( )
Gallbladder trouble/stones ( )
Intolerance to fried
or fatty foods ( )
Bloating/ Belching ( )
Hiatal hernia ( )
GERD ( )
Burning beneath the
breast bone ( )
Bloody/ tarry stools ( )
Clay-colored stools ( )
Heartburn ( )
Ulcers ( )
Abdominal pain ( )
relieved with antacids ( )
Vomited blood ( )
Diarrhea (persistent) ( )
Constipation requiring
laxatives ( )
Hemorrhoids ( )
Other ( )
Comments:

G.U. (GENITOURINARY):

Nephritis ( )
Kidney stones ( )
Kidney infection ( )
Blood in urine ( )
Pus in urine ( )
Sugar or albumin in urine ( )
Frequent burning on urination ( )
Bladder infection ( )
Prostate problems ( )
Do you get up at night ( )
to void? Yes/ No
Difficulty starting urine
stream? Yes/ No
Rupture of hernia ( )

ENDOCRINE, METABOLIC INFECTIONS, HEMATOLOGIC

Diabetes ( )
Cholesterol/Triglycerides ( )
Gout ( )
Hemophilia ( )
Hypoglycemia ( )
Sickle cell disease ( )
Anemia (tired blood) ( )
Lymph node swelling ( )
Bleeding disorders
Excess bleeding after ( )
injury or dental work ( )
Easy bruising ( )
Fevers ( )
Tropical infections ( )

Continued on page 3

NEUROMUSCULAR:

Back pain (recent/chronic) ( )
Trick or locked knee ( )
Amputation (any body parts) ( )
Swollen/ painful joints ( )
Arthritis/ rheumatism-where? ( )

_____

Bursitis-where?_____ ( )
Paralysis/ tremors ( )
Other/ comments: ( )

_____

_____

PSYCHIATRIC: ( )
Nervous trouble ( )
Excessive worry ( )
Depression ( )
Trouble sleeping ( )
Attempted suicide ( )
Hospitalization for
nervous problems ( )
Sexual problems ( )

VASCULAR:

Varicose veins ( )
Bleeding in the legs ( )
Ulcers in the legs ( )
Clots in legs/phlebitis ( )
Deep (DVT) ( )
Superficial (SVT) ( )
Clots to lungs ( )
Swelling ( ) Stretching ( )
Pain ( ) Pulling ( )
Aching ( ) Burning ( )
Heaviness ( ) Numbness ( )
Throbbing ( ) Tingling ( )
Itching ( ) Tenderness ( )
Cramps (legs/thighs) ( ) Relief w elevation ( )
Coldness(hands/feet) ( ) Strokes ( )
Restless legs ( ) Pain on walking ( )
Arterial Disease ( )

Other/ comments: _____

_____

_____

FOR FEMALES ONLY:

Have you ever been treated for
female disorders ( )
Are you pregnant? Yes/ No
Are you breast feeding? Yes/ No
Leg Discomfort
During Periods ( )
Vaginal Varicose Veins
During Pregnancy ( )
Pelvic or inner thigh Veins during:
Intercourse ( )
Periods ( )
Standing ( )

Number of pregnancies_____
Number of miscarriages_____
Number of abortions_____
Number of living children_____
If past menopause, what age did
your periods stop? _____
Date of last pelvic exam_____

FAMILY HISTORY:

	Age if Living	Condition of Health: If not Good, Details	Age at Death	Cause of Death	Bleeding or Neurological Disorders Cancer, Diabetes, TB, Hereditary Diseases
Father					
Mother					
Brothers					
Sisters					
Children					

(1) Have you experienced any significant complications with anesthetics or operations?

_____

_____

_____

_____

(2) Has any family member experienced any significant complications with anesthetics?

_____

_____

_____

(3) Have you had any blood transfusions?

_____

_____

_____

If you feel uncomfortable answering any of the above questions please discuss them with the doctor.

Please be aware that many major surgical procedures require another surgeon to assist during the procedure. If you have questions or concerns about an assistant surgeon, please feel free to ask the doctor.

Vein Center of New Mexico, LLC

Medical History Please circle appropriate answer

Name: _____ Date: _____

1.	Have you ever had a blood clot in your legs or lungs?	Yes	No	(3)
2.	Do you have a family history of blood clots in the veins?	Yes	No	(3)
3.	Do you have leg swelling every day?	Yes	No	(1)
4.	Do you have visible varicose veins or spider veins?	Yes	No	(1)
5.	Do you have inflammatory bowel disease?	Yes	No	(1)
6.	Do you have emphysema or COPD?	Yes	No	(1)
7.	Have you had more than three days of continuous bed rest due to injury or illness in the past month?	Yes	No	(1)
8.	Have you had a pelvic fracture or a plaster leg cast in the last month?	Yes	No	(1)
9.	Have you had a stroke, heart attack, or heart failure?	Yes	No	(1)
10.	Have you had major surgery lasting over an hour in the last month?	Yes	No	(1)
11.	Do you have or have you had a malignant disease (cancer)?	Yes	No	(1)
12.	Do you weigh over 250 pounds?	Yes	No	(1)
13.	AGE: (please circle) Under 40 40-59 (1) 60-69 (2) Over 70 (3)			

The following questions are for WOMEN only:

14.	Do you use birth control pills or estrogen replacement therapy?	Yes	No	(1)
15.	Are you pregnant or have you had a baby within the last month?	Yes	No	(1)

The result from our examination is as follows: **TOTAL:** _____

Risk of venous thromboembolism (clot):

Risk Score	Risk Level	% Risk for DVT
0 - 1	Low	10%
2	Moderate	10% - 20%
3-4	High	20% - 40%
> 5	Very High	40% - 80%

Risk Score: _____

Quality of Life Questionnair

Emotional Questions

Leg problems may also have an effect on your morale. To what extent do the following sentences correspond to the way you have felt during the past four weeks?

1. I feel on edge	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
2. I become tired easily	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
3. I feel I am a burden to people	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
4. I must always take precautions	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
5. I am embarrassed to show my legs	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
6. I get irritated easily	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
7. I feel handicapped	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
8. I have difficulty getting going in the morning	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time
9. I do not feel like going out	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ All the Time

Physical Questions

The following questions are concerned with symptoms, sensations or discomforts related to your patient's lower extremities, which may make daily tasks difficult for them. If your patients suffer from any of these problems, please answer the questions below, selecting the corresponding description according to the intensity felt.

1. If you have any pain in your ankles or legs, what was the intensity of the pain?	○ No Pain ○ Light Pain ○ Moderate Pain ○ Strong Pain ○ Intense Pain
2. To what extent do you feel bothered/limited in your work or your other activities because of your leg problem?	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
3. Have you slept badly because of your leg problems, and if so, how often?	○ Never ○ Seldom ○ Fairly Often ○ Very Often ○ Every Night
4. Standing	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
5. Climbing	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
6. Crouching/Kneeling	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
7. Walking Briskly	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
8. Travel by Car, Bus or Plane	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
9. Housework (cleaning, chores, etc.)	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
10. Attending Social Functions (parties, weddings, etc.)	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
11. Sporting Activities or Strenuous Physical Activity	○ Not Bothered ○ Little Bothered ○ Moderately Bothered ○ Very Bothered ○ Extremely Bothered
Survey Completion Date:	[redacted]