



**VEIN CENTER**  
of NEW MEXICO™



**NEW PATIENT  
WELCOME PACKET**

Rev. 10/2018



**VEIN CENTER**  
of NEW MEXICO™

**MICHAEL B. HARDING, MD, FACC, RPVI**  
Board Certified in Vascular Medicine, Cardiology, Internal Medicine

## **WELCOME!**

Thank you for choosing Vein Center of New Mexico for your venous care. Please complete the forms in this packet before arriving at our office.

**Your appointment is scheduled on \_\_\_\_\_ at \_\_\_\_\_  
with Dr. Michael Harding.**

Please bring your completed forms to your appointment. If you should forget these forms, it will cause a delay in seeing the physician and the appointment may need to be rescheduled.

Please note, if your insurance requires a referral for your appointment and we do NOT have a copy when you arrive, your appointment will have to be cancelled.

Our self-pay policy (if you don't have insurance) is to collect 30% down at the time of your visit. If you have any questions regarding your insurance or payments, please call our office to discuss your situation with our billing staff.

Please arrive 10-15 minutes before your scheduled appointment time, to allow for the check-in process. If you arrive late for your appointment, the services we can provide may be limited, or we may need to reschedule. Our office will call to confirm your appointment 2 days in advance.

You should expect to spend approximately 1-1/2 - 2 hours for your new patient visit. Please do not bring small children.

If you have any questions prior to your visit, please contact our office at 505-247-4849 - we're here to help you!

**Thank you for choosing us for your vein health!**  
**Prior to your appointment, please visit our website:**

**<http://www.veincenternm.com>**

**You can also follow us on [Facebook](#), [Twitter](#) and [YouTube](#)**



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## **APPOINTMENT CHECKLIST**

- Please eat before your appointment.**
- Do not wear support hose for 2 days before your appointment.**
- Bring a loose-fitting, wide-leg pair of shorts for your ultrasound**
- Bring all medications you are currently taking, or a list of your medications, including dosage and frequency.**
- Complete and bring all forms enclosed in this packet.**



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## **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 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



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## 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.

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date

\* This waiver is valid for one year from the signature date.



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## **ACKNOWLEDGEMENT 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.**

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Patient Name (Type or Print)

---

Patient's Date of Birth

---

Signature of Patient or Parent/Legal Guardian

---

Date



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## **HIPAA Notice of Privacy Practices**

*Effective April 14, 2013 \* Revised May 23, 2018*

**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.



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## **HIPAA Notice of Privacy Practices (continued)**

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.**

**HIPAA COMPLIANCE OFFICER: Liz Ford, Practice Manager**

**Phone: 505-247-4849**

**Email: [lford@veincenternm.com](mailto:lford@veincenternm.com)**

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 HIP AA 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 receive or been given the opportunity to receive a copy of our Notice of Privacy Practices.





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## Authorization to Release / Request Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

I, \_\_\_\_\_, hereby request and authorize all medical records of the above named patient be released/requested to/from:

\_\_\_\_\_  
Name of Physician / Facility

\_\_\_\_\_  
Address of Physician / Facility

\_\_\_\_\_  
Phone # / Fax # of Physician / Facility

Please fax all medical records to:  
**VEIN CENTER OF NM, LLC**  
801 Encino Pl. NE, Suite C-12  
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



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**PATIENT INFORMATION**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

**Sex:**     Male  
           Female

**Marital Status:**     Single  
                           Married  
                           Divorced

**Employer:** \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary 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**

Insured Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Group # \_\_\_\_\_

Patient ID: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

**INSURANCE INFORMATION / SECONDARY**

Insured Name: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Group # \_\_\_\_\_

Patient ID: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## Patient Medical History Questionnaire

This questionnaire is designed to facilitate our evaluation of your medical issues.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Referring Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_

Please put a checkmark next to positive findings below:

### 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 (circle)
- Hiatal Hernia
- High Blood Pressure
- High Cholesterol
- Inflammatory Bowel Disease
- Chron's Disease
- Colitis
- Kidney Disease
- Liver Disease
- Mononucleosis
- Obesity-Overweight
- Osteoporosis/Osteopenia
- Prostate Disease
- Seizures/Epilepsy
- Sleep Apnea
- Stroke
- Thyroid Disease
- Tuberculosis
- Other medical issues not listed \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICATIONS (present and past 6 weeks)

- (Please include dosage)
- Antacids
  - Antibiotics
  - Antidepressants
  - Birth Control
  - Oxygen
  - Blood Thinners:**
  - Coumadin, Lovenox, Xarelto, Eliquis, 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
- Other allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PERSONAL/SOCIAL

- Single / Married / Divorced / Widowed
- Tobacco: Use now or before  
Packs/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, please include year)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



## Patient Medical History Questionnaire (continued)

### Review of Systems

**SKIN:**

- Tattoos
  - Rashes
  - Warts
  - Tumors / Cysts
  - Boils
  - Cancer
  - Other
- 
- 
- 

**HEAD:**

- Migraine headaches
  - Frequent/severe headaches
  - Loss of consciousness
  - Loss of memory (amnesia)
  - History of concussion
  - Brain injury
  - Other
- 
- 
- 

**EYES:**

- Blurring
  - Double vision
  - Blindness
  - Wear glasses
  - Near sighted vision
  - Far sighted vision
  - Glaucoma
  - Cataracts
  - Spots in vision
  - Other
- 
- 
- 

**NOSE:**

- Sinusitis
  - Chronic/frequent colds
  - Severe nosebleeds
  - Other
- 
- 
- 

**MOUTH:**

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

**EAR/NOSE/THROAT:**

- Vertigo
  - Hearing loss
  - Infections
  - Ear aches
  - Other
- 

**NECK:**

- Thyroid Disease
  - Goiter
  - Hoarseness
  - Heat intolerance
  - Cold intolerance
  - Seizures (fits)
  - Other:
- 

**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
- Palpitations/pounding heart
- Nitroglycerine use? YES / NO
- Heart murmurs
- Mitral valve prolapse

**BREASTS:**

- Tumors
  - Nipple bleeding/discharge
  - Pain
  - Family History of breast cancer YES / NO
  - Other
- 

**G.I. (GASTROINTESTINAL)**

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

**G.I. (continued)**

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

**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



### Patient Medical History Questionnaire (continued)

**NEUROMUSCULAR:**

- Back pain (recent/chronic)
- Trick or locked knee
- Amputation (any body part)
- Swollen/painful joints
- Arthritis/rheumatism
- If so, where? \_\_\_\_\_

---

- Bursitis - if so, where?

---

- Paralysis/tremors
- Other \_\_\_\_\_

---

**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
- Pain
- Aching
- Heaviness
- Throbbing
- Itching
- Cramps(legs/thighs)
- Cold (hands/feet)
- Restless legs
- Arterial disease
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- Stretching
- Pulling
- Burning
- Numbness
- Tingling
- Tenderness
- Relief w/elevation
- Strokes
- Pain on walking

**FEMALES ONLY:**

- Ever treated for female disorders? Y / N
- Are you pregnant? Y / N
- Breast feeding? Y / N
- 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, at what age did your periods stop? \_\_\_\_\_
- Date of last pelvic exam: \_\_\_\_\_

**FAMILY HISTORY:**

	Age (if living)	Condition of health (if not good, explain)	Age at death	Cause of death	Bleeding/neurological disorders Cancer,Diabetes,TB,Hereditary
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Have you experienced any significant complications with anesthetics or operations?  
\_\_\_\_\_  
\_\_\_\_\_

Has any family member experienced any significant complications with anesthetics?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any blood transfusions?  
\_\_\_\_\_

*If you feel uncomfortable answering any of the above questions, please discuss them with your 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.*



### Patient Medical History Questionnaire (continued)

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS:

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 3 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 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%
Greater than 5	VERY HIGH	40% - 80%

**RISK SCORE:** \_\_\_\_\_



## Patient **QUALITY OF LIFE** Questionnaire

### 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"                               | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 2. I become tired easily                          | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 3. I feel I am a burden to people                 | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 4. I must always take precautions                 | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 5. I am embarrassed to show my legs               | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 6. I get irritated easily                         | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 7. I feel handicapped                             | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 8. I have difficulty getting going in the morning | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |
| 9. I do not feel like going out                   | <input type="checkbox"/> Never | <input type="checkbox"/> Seldom | <input type="checkbox"/> Fairly often | <input type="checkbox"/> Very often | <input type="checkbox"/> All the time |

### PHYSICAL QUESTIONS

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

- 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
- To what extent do you feel bothered/limited in your work or other activities because of your leg problem?  
 Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Have you slept badly because of your leg problems, and if so, how often?  
 Never    Seldom    Fairly often    Very often    Every night
- Standing    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Climbing    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Crouching / kneeling    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Walking briskly    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Travel by car, bus or plane    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Housework (cleaning, chores, etc.)    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Attending social functions (parties, wedding, etc.)    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered
- Sporting activities or strenuous physical activity    Not bothered    A little bothered    Moderately bothered    Very bothered    Extremely bothered

SURVEY COMPLETION DATE: \_\_\_\_\_



**VEIN CENTER**  
of NEW MEXICO™

**MICHAEL B. HARDING, MD, FACC, RPVI**  
Board Certified in Vascular Medicine, Cardiology, Internal Medicine

## DETAILED DIRECTIONS TO OUR OFFICE

### TRAVELING SOUTH ON I-25:

Exit 1-25 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 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.

### TRAVELING WEST ON LOMAS BLVD:

Just before you go under the 1-25 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 1-25 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.

