John D. Horowitz, M.D., F.A.C.S.
Board Certified, Vascular Surgery
Diplomate of the American Board of
Venous and Lymphatic Medicine

Harry Agis, M.D., F.A.C.S.
Board Certified, Surgery
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CENTRAL FLORIDA
VEIN & VASCULAR CENTER
THE DIAGNOSTIC VASCULAR LABORATORY | ACR ACCREDITED FACILITY

Todd Hansen M.D., F.A.C.E.P.
Diplomate of the American Board
of Venous and Lymphatic Medicine

Rafael Quinones, M.D., F.A.C.S.
Board Certified, Surgery

Ammar Saati, M.D., F.A.C.P.
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of Venous and Lymphatic Medicine

Jessica Lebron, APRN
Nurse Practitioner

Amber Werner, APRN
Nurse Practitioner

Shaihanne Singh, APRN
Nurse Practitioner

Paige Mackenzie Cupp, PA-C
Physician Assistant

Welcome to our Practice!

Please completely fill out the enclosed patient information forms and bring the **completed** forms to our office on your appointment date. Completing these forms in their entirety **prior** to your appointment will help your appointment to run more smoothly.

Also, please remember to bring a **PHOTO ID**, your **INSURANCE CARD(S)**, **COPAY**, and a **COMPLETE LIST OF YOUR MEDICATIONS** (including the medication name(s), dosages and how often you take them).

Please **BRING** a pair of loose-fitting **SHORTS** with you to change into for your exam.

Should you have any questions please feel free to call our office. Thank you and we look forward to seeing you!

Sincerely,

Surgical Specialists of Central Florida
Central Florida Vein & Vascular Center

JOHN D. HOROWITZ, M.D.
HARRY AGIS, M.D.
TODD HANSEN, M.D.
RAFAEL QUIONES, M.D.
AMMAR SAATI, M.D.

CENTRAL FLORIDA VEIN & VASCULAR CENTER

Patient Name *(Nombre del Paciente)*	DOB *(Fecha de Nacimiento)*	SS# *(Seguro Social)*	Sex *(Sexo)*	Marital Status *(Estado Civil)*

Ethnicity □ Latino/Hispanic □ Other □ Not Reported/Refused

Select Race □ Caucasian □ Black □ Hispanic □ Asian □ Native American
□ Subcontinent Asian American □ Pacific Islander □ Asian Pacific American □ Native Hawaiian
□ American Indian or Alaskan Native □ Black Non-Hispanic □ White Non-Hispanic □ Other Race or Ethnicity

Gender Identity □ Male □ Female □ Transgender □ Declined □ Other _____

Street Address *(Dirección)*				Home Phone *(Telefono De Hogar)*
City *(Ciudad)*	**State** *(Estado)*	**Zip Code** *(Código Postal)*	**Alternate Phone** *(Otro Telefono)*	**Cell Phone** *(Numero De Celular)*
Place of Employment *(Sitio de Empleo)*	**Occupation** *(Ocupacion)*			**Work Phone** *(Telefono de Su Trabajo)*

Name of Spouse *(Nombre de su Esposo/Esposa)*	Email Address *(Dirección Electrónica)*
Nearest Relative not living with you *(Familiar cercano que no viva con usted)*	**Phone #** *(Telefono)*
Emergency Contact *(Contacto de Emergencia)*	**Phone #** *(Telefono)*

Primary Insurance *(Seguro Primario)*	Subscriber's Name/DOB *(Nombre del Responsible/Fecha de Nacimiento)*	Policy ID# *(Numero de Poliza)*	Group # *(Numero de Group)*
Insurance Claims Address *(Dirección de la Compania de Seguro)*		**Insurance Phone** *(Telefono del Seguro Medico)*	
Secondary Insurance *(Seguro Secundario)*	**Subscriber's Name/DOB** *(Nombre del Responsible/Fecha de Nacimiento)*	**Policy ID#** *(Numero de Poliza)*	**Group #** *(Numero de Group)*
Insurance Claims Address *(Dirección de la Compania de Seguro)*		**Insurance Phone** *(Telefono del Seguro Médico)*	

Relationship to Patient *(Relacion al Paciente)*	If other than patient, Insured SS# *(Seguro Social del Responsible del Seguro)*	If other than patient, DOB *(Fecha de Nacimiento del Responsible)*

Prescriptions are sent directly to your pharmacy. We will need the following information.

Pharmacy Name *(Nombre de la Farmacia)*:	Pharmacy Phone *(Telefono de la Farmacia)*:
Pharmacy Address *(Dirección de la Farmacia)*:	Pharmacy Fax *(Faximile de la Farmacia)*:

Referred by: ☐ Self ☐ Internet ☐ Television ☐ Family ☐ Friend ☐ Other

☐ Physician _____

I authorize the Physicians and Physician's associates of Surgical Specialists of Central Florida to render medical care to the above named patient. I acknowledge that all information listed above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize release of any medical information necessary to process and insurance claim on my behalf. This signed agreement will act as a valid facsimile of the original.

Patient's Signature_____ Date _____
(Firma del Paciente) *(Fecha)*

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CANCELLATION OF APPOINTMENTS

OUR OFFICE REQUIRES A 48-HOUR NOTICE FOR CANCELLATION OF APPOINTMENTS. IF YOU FAIL TO GIVE OUR OFFICE A 48-HOUR NOTICE OR IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, THERE WILL BE A $50.00 CHARGE BILLED DIRECTLY TO YOU.

THANK YOU,
CENTRAL FLORIDA VEIN & VASCULAR CENTER

PATIENT'S NAME: _____

PATIENT'S SIGNATURE _____

TODAY'S DATE _____

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PRIVACY PRACTICE ACKNOWLEDGEMENT

I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES AND MAY ALSO REQUEST A COPY TO KEEP FOR MYSELF IF I SO CHOOSE.

NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

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ABOUT YOUR MEDICAL RECORDS

Information found in medical records is confidential. Healthcare workers are mandated by law and by professional standards to protect patient confidentiality. Your record is the physical property of Surgical Specialists of Central Florida Inc dba Central Florida Vein & Vascular Center. However, the patient controls the release of the information contained in the record.

In general, you must give permission for anyone, other than a member of your established healthcare team, to have access to your medical record. By law, your records may be disclosed without your permission under certain circumstances such as in response to a subpoena or court order, to certain government and regulatory bodies, to someone who holds your power of attorney, to someone you have designated as your healthcare surrogate, to another established healthcare provider for continued care, and to your healthcare insurer to obtain reimbursement for your care.

If you should need copies of your medical record for services received at Surgical Specialists of Central Florida Inc dba Central Florida Vein & Vascular Center, please contact our office. We will need **prior** notification, along with a properly executed Authorization to Release PHI (protected health information/medical Information) form before we can release any medical information, as there are specific Federal guidelines that we are required to follow. In addition, you will need to provide us with proof of identification (your driver's license or state ID), and after comparing your signature with the one we have on file, we will release the medical information that you are requesting. For your convenience, you may access the form from our website (www.cfvein.com).

In order for your power of attorney, healthcare surrogate or personal representative to obtain copies of your records, we must be provided a copy of the properly executed documents designating the individuals as such to keep in our files.

After receiving the properly executed form(s), copies will be available **for your pick up within seven working days**. This time frame allows us to conduct our research and ensures the availability of the requested information.

The records are generally burned to a CD in PDF file. Should you prefer your records in a different format, please indicate this at the time of request. There may be a nominal charge to offset the costs of providing your copies.

Health Central
10000 West Colonial Drive
Suite 495
Ocoee, Florida 34761

Kissimmee
1130 Cypress Glen Circle
Kissimmee, Florida 34741

The Villages
13953 NE 86th Terrace
Suite 101
Lady Lake, Florida 32159

Fax: 407.293.7355 • 407.293.5944 • www.cfvein.com
Operating as: Surgical Specialist of Central Florida, Inc.

COMMUNICATIONS AGREEMENT

In order to keep pace with electronic communications and comply with governmental regulations, please let us know how you would like us to communicate with you.

PLEASE CHECK APPROPRIATE BOXES BELOW & INDICATE PRIORITY (1st, 2nd or 3rd) OF NUMBERS

Priority

☐ ***Home Telephone*** # _____ -_____- _____

☐ OK to leave **voice** message with detailed information

☐ Leave message with call back number only

Priority

☐ ***Cellular Telephone*** # _____ -_____- _____

☐ OK to leave **voice** message with detailed information

☐ Leave message with call back number only

☐ OK to send text message (Opt In) Cell Phone Carrier _____

Priority

☐ ***Work Telephone*** # _____ -_____- _____

☐ OK to leave **voice** message with detailed information

☐ Leave message with call back number only

Email Address : _____

☐ OK to send email message with detailed information

Written Communication

Mail will be sent to the home address provided to practice.

I agree and consent to the Practice releasing information to myself in the above manners.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Central Florida Vein & Vascular Center in writing. The revocation shall be effective *except* to the extent that Central Florida Vein & Vascular Center has already taken action in reliance on the Consent.

Patient Name: _____ Date: _____

Signature: _____

CENTRAL FLORIDA VEIN & VASCULAR CENTER

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND COMMUNICATION WITH FAMILY AND FRIENDS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Surgical Specialists of Central FL (the "Practice") in order to carry out treatment, payment, or health care operations.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Family and Friends. It is the office policy of Surgical Specialists of Central Florida not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not list anyone below, your medical information will not be released except as stated in this signed Consent. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing.)

Spouse: _____ Parent: _____

Other: _____ Other: _____

Other: _____ Other: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)
By signing below, you are authorizing the office to release any and all information regarding:

☐ HIV/AIDS/Sexually Transmitted Diseases ☐ Drugs/Alcohol ☐ Mental Health

Signature: _____

At all times, Patient retains the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

«PatientFullName» _____ _____

Print Name | Signature of Patient (Authorized Representative*) | Date

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient (Proof of authorization must be provided):

_____

CENTRAL FLORIDA VEIN & VASCULAR CENTER

Name *(Paciente)*: _____ **DOB** *(Fecha de Nacimiento)*: _____

Reason for Visit ***(Razon de su Visita)*** **:**	
Referring Physician ***(Doctor que lo Refiere)*** **:**	**Primary Care Physician** ***(Doctor Primario)*** **:**
Other Specialists/Surgeons ***(Otro Especialistas/Cirujanos)*** **:**	

HISTORY OF PRESENT ILLNESS

☐ High Blood Pressure *(Presión Alta)* Date of Onset_____/_____/_____	☐ Smoker *(Fumas)*
Low Blood Pressure *(Presión Baja)*	Tobacco Use *(Usó de tabaco)* _____ Pack(s) per day *(Paquetes por día)* _____ How many years *(Cuantos anos)*

Are your legs ever bothered by *(Ha sentido alguna vez en sus piernas)* :

☐ Aching/Pain *(Ardor/Dolor)*	☐ Discoloration *(Decoloración)*
☐ Cramping *(Calambres)* ☐ Increases with walking *(Aumenta al caminar?)*	☐ Swelling/Fullness/Heaviness/Pressure *(Hinchazón/Llenura/Pesadez/Presión)*
☐ Numbness *(Entumecimiento)*	☐ Elevation of Legs *( )* ☐ Excercises for lower extremities *( )*
☐ Burning *(Quemazón)*	☐ Take NSAIDS? *(Toma anti-inflamatorios?)*
☐ Restlessness *(Inquietud)*	☐ Prescription Stockings *(Medias de compression recetadas)*
☐ Tiredness *(Cansancio)*	☐ Vein Hemorrhage *(Hemorragia en las venas)* ☐ Single/minor *(menor)* ☐ Significant major *(mayor)* ☐ Transfusion required *(Necesitó transfusion?)*
☐ Wounds *(Heridas ó llagas)*	
☐ Throbbing/Tingling *(Pulsaciones/Punzadas)*	
☐ Itching *(Picazon)*	
☐ Trauma/Surgery of Lower Extremity *(Trauma/Cirugía de la extremidad inferior)*	☐ Other *(Otros)*

Occupation: *(Ocupación)*	
Job physical requirements include: *(Requisitos físicos de trabajo incluyen:)*	
Unable to sit *(Incapaz de sentarse)* ☐ more than 30 min *(Más de 30 min)* ☐ more than 1 hr *(Más de 1 hr)*	Unable to lift *(Incapaz de levanter)* ☐ 0-10 pounds *(0-10 libras)* ☐ 10-20 pounds *(10-20 libras)*
Unable to walk more than 1 hr *(Incapaz de caminar más de 1 hr)*	Unable to take care of household chores *(Incapaz de hacerse cargo de las tareas del hogar)*
☐ Unable to perform manual task *(Incapaz de realizar tarea manual)*	
☐ Unable to: *(Incapaz de:)* ☐ kneel *(arrodillarse)* ☐ squat *(agacharse)* bend *(doblarse)* climb *(subir)* sleep *(dormer)*	
☐ Unable to perform daily activities due to: *(Incapaz de realizar actividades diarias debido a:)* ☐ leg pain *(dolor de pierna)* ☐ swelling *(hinchazón)*	
Potential limitations with work activity: *(Posibles limitaciones con las actividades del trabajo:)*	
Limited in ability to do work due to moderate/severe leg symptoms? *(Posibles limitaciones con las actividades del trabajo:)* ☐ Yes *(Si)* ☐ No *(No)*	

Name *(Paciente)*:_____ **DOB** *(Fecha de Nacimiento)* _____

PAST MEDICAL HISTORY

☐ Coronary Artery Disease *(Enfermedad de las Arterias Coronarias)*	☐ Mitral Valve Prolapse *(Prolapso de la Valvula Mitral)*	☐ Diabetes Mellitus *(Diabetes)* ☐ IDDM Insulin *(Insulina)* ☐ NIDDM Non-Insulin *(Sin Insulina)*
Heart Attack *(Infarto)*	Aneurysm *(Aneurisma)*	COPD- Chronic Obstructive Pulmonary Disease *(Efisema o Bronquitis)*
Congestive Heart Failure *(Insuficiencia Cardiaca)*	Carotid Stenosis *(Enfermedad de las Carotidas)*	Asthma *(asma)*
Stress Test *(Prueba de Esfuerzo)*	TIA-Transischemic Attack (Mini Stoke) *(Ataque Isquémico Transitorio)*	Blood Clot/DVT *(Coágulos)*
Echocardiogram *(Ecocardiograma)*	CVA-Cerebrovascular Accident (Major Stoke) *(Derrame Cerebral)*	Lymphedema Arm/Leg Swelling *(Brazo/Piernas Hinchadas)*
Atrial Fibrillation/Fast Heart Beat *(Fibrilacion Auricular/Palpitaciones)*	Open Wounds *(Heridas Abiertas/Ulceras)*	Anemia- Low Iron Count *(Cuenta de Hierro Baja/Anemia)*
High Cholesterol *(El Colesterol alto)*	Gout *(Góta)*	
Peripheral Vascular Disease *(Enfermedad Vascular Periferica)*	Arthritis *(Artritis)*	Fibromyalgia *(Fibromialgia)*
Cancer *(Cancer)* Radiation *(Radiación)* Type *(Tipo)*	Blood Disease/Disorder *(Enfermedad de la Sangre)* Type *(Tipo)*	# of Pregnancies_____ *(Numero de embarazos)*

☐ CABG Heart Bypass *(Bypass o Puentes Coronarios)*	☐ Pacemaker Defibrillator *(Marcapaso o Desfibriladores)*
Heart Valve Replacement *(Reemplazo de Valvula Cardiaca)*	Heart Cath *(Cateterismo Cardiaco)*

Name *(Paciente)*: _____ **DOB** *(Fecha de Nacimient):* _____

PAST SURGICAL HISTORY *(Cirugias Previas)*

Peripheral Vascular Procedures *(Procedimientos Vasculares Perifericos)*

- ☐ Bypass Graft or Revision *(Puentes Vasculares)* ☐ Left Leg *(Pierna Izquierda)* ☐ Right Leg *(Pierna Derecha)*
- ☐ Carotid Artery Surgery (*Cirugia de Venas Carotida)* ☐ Left *(Izquierda)* ☐ Right *(Derecha)*
- ☐ Aneurysm Repair (*Aneurismas)*
  - ☐ Abdominal Aortic *(Aorta Abdominal)*
  - ☐ Popliteal Artery *(Arteria Poplitia)*
  - ☐ Open *(Abierto)*
  - ☐ Iliac Artery *(Arteria Iliaca)*
  - ☐ Endovascular *(Tratamiento Endovascular)*
- ☐ Cardio Vascular Procedures *(Procedimientos Cardiovasculares)* :

EndoVascular Procedures *(Tratamiento Endovascular)*

- ☐ NonCoronary Angiography *(Angiograma de las Arterias Perifericas)* ☐ Left Leg *(Pierna Izquierda)* ☐ Right Leg *(Pierna Derecha)*
- ☐ Intravascular Stent Placement *(Colocacion de Stents)* ☐ Left Leg *(Pierna Izquierda)* ☐ Right Leg *(Pierna Derecha)*

Orthopedic *(Ortopedico)*

- ☐ Hip Replacement *(Reemplazo de Cadera)* ☐ Left *(Izquierda)* ☐ Right *(Derecha)*
- ☐ Knee Replacement *(Reemplazo de Rodilla)* ☐ Left *(Izquierda)* ☐ Right *(Derecha)*
- ☐ Foot Surgeries *(Cirugia de los Pies)* ☐ Left *(Izquierda)* ☐ Right *(Derecha)*
- ☐ Amputation *(Amputacion)*
  - ☐ Left Leg *(Pierna Izquierda)* When *(Cuando)* : Above *(Arriba de)* / Below Knee *(Debajo de)*
  - ☐ Right Leg *(Pierna Derecha)* When *(Cuando)* : Above *(Arriba de)* / Below Knee *(Debajo de)*
  - ☐ Other *(Otra)*

General Surgery Procedures *(Cirugia General)*

- ☐ Hernia Surgery *(Cirugia de Hernia)* ☐ Groin *(Inguinal)* ☐ Left *(Izquierdo)* ☐ Right *(Derecha)*
- ☐ Skin Debridement *(Limpieza de Heridas)*
- ☐ Wound Care *(Cuidado de Heridas)* ☐ Left Leg *(Pierna Izquierda)* ☐ Right Leg *(Pierna Derecha)*
- ☐ Gastric Surgery *(Cirugia Garstrica)* ☐ Bypass *(Bypass)* ☐ Banding *(Banda o anillo)*
- ☐ Other Surgeries/Procedures *(Otras Cirugias)*

Vein Procedures *(Procedimientos de las Venas)*

- Inferior Vena Cava Filter/IVC Filter *(Filtro de la Vena Cava Inferior)*
- Varicose Vein Surgery (*Cirugia de Venas Varicosa)* Left Leg *(Pierna Izquierda)* When *(Cuando)* : Right Leg *(Pierna Derecha)* When *(Cuando)* :
- Sclerotherapy Injections (*Injecciones de Escleroterapia)* Left Leg *(Pierna Izquierda)* # of Treatments *(# de Tratamientos)*_____ Right Leg *(Pierna Derecha)* # of Treatments *(# de Tratamientos)*_____

Name *(Paciente)*:_____ **DOB** *(Fecha de Nacimiento)*: _____

Review of Symptoms *(Revisar de Sintomas)*

- ☐ Recent Illness *(Enfermedades Recientes)*
- ☐ Fever *(Fiebre)*
- ☐ Recent Weight Change *(Cambio de Peso Reciente)*
- ☐ Headaches *(Dolores de Cabeza)*
- ☐ Feeling Fine *(Se Siente Bien)*
- ☐ Eye/Vision Problems *(Problemas de Visión)*
- ☐ Wears Glasses *(Usa Lentes/Espejuelos)*
- ☐ Blindness *(Ceguera)*
  - ☐ Left Eye*(Ojo Izauierdo)* ☐ Right Eye *(Ojo Derecho)*
- ☐ Temporary Vision Loss*(Perdida Transitoria de la Visión)*
  - ☐ Left Eye*(Ojo Izauierdo)* ☐ Right Eye *(Ojo Derecho)*
- ☐ ___Hearing Loss *(Perdida de Audición)*
  - ☐ Left Ear*(Oido Izauierdo)* ☐ Right Ear*(Oido Derecho)*
- ☐ Difficulty Swallowing *(Dificultad al Tragar)*
- ☐ Neck Pain *(Dolor de Cuello)*
- ☐ Jaw Pain During Exercise *(Dolor de la Quijada Durante Ejercicios)*
- ☐ Chest Pain or Discomfort *(Dolor o molestia en el Pecho)*
- ☐ Anxiety *(Ansiedad)*
- ☐ Depression *(Depresión)*
- ☐ Bleed Easily *(Sangra Fácilmente)*
- ☐ Bruise Easily *(Hace Hematomas Fácilmente)*
- ☐ Soft Tissue Swelling
- ☐ Blood Thinners *(Coagulantes)*
- ☐ Abdominal Pain *(Dolor abdominal)*
- ☐ Nausea *(Náusea)*
- ☐ Vomiting *(Vómitos)*
- ☐ Shortness of Breath *(Falta de aliento)*
- ☐ Dizziness *(Mareos)*
- ☐ Lightheadedness *(Sensación de Desvanecimiento)*
- ☐ Fainting *(Desmallos)*
- ☐ Convulsions/Seizure Disorder *(Convulsiones/Epilepsia)*
- ☐ Palpitations/Fast Heart Rate *(Palpitaciones)*
- ☐ Slow Heart Rate *(Latidos lentos del Corazon)*
- ☐ Cold Hands/Feet *(Manos Frias/PiesFrios)*
- ☐ Skin Wound or Ulcer *(Ulceras/heridas en la piel)*
- ☐ Leg Symptoms *(Dolor en las Piernas)*
- ☐ Leg Pain with Exercise *(Dolor de Pierna Durante el Ejercicio)*
- ☐ Back Symptoms *(Molestias en la Espalda)*
- ☐ Hip Symptoms *(Molestias en las Caderas)*
- ☐ Chronic Cough *(Tos Cronica)*
- ☐ Dry Skin *(Piel Seca)*
- ☐ Cracking of Skin *(Piel Cuarteada)*

FAMILY HISTORY *(Historia Familiar)*

☐ **Cancer** *(Cancer)*	☐ Mother *(Madre)* ☐ Father *(Padre)* ☐ Sister *(Hermana)* ☐ Brother *(Hermano)* ☐ randparent Maternal/Paternal *(Abuelos Maternos/Paternos)*
Heart Disease *(Enfermedades Cardiacas)*	Mother *(Madre)* ☐ Father *(Padre)* ☐ Sister *(Hermana)* ☐ Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)*
High Blood Pressure *(Presión Alta)*	Mother *(Madre)* ☐ Father *(Padre)* ☐ Sister *(Hermana)* ☐ Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)*
Early Deaths *(Muertes a terprana edad)*	Mother *(Madre)* ☐ Father *(Padre)* ☐ Sister *(Hermana)* ☐ Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)* ☐
Diabetes *(Diabetis)*	Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)* ☐
Aneurysm *(Aneurisma)*	Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)* ☐
Blood Clots *(Coágulos en la Sangre)*	Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)*
CVA - Cerebrovascular Accident/Major Stroke *Accidente-Cerebrovascular/Derrame)*	☐ ☐ ☐ ☐ Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)* ☐
TIA – Trans Ischemic Attack/Mini Strokes *(Ataque Isquémico)*	Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)* ☐ ☐ ☐
Varicose Veins *(Venas Varicosas)*	Mother *(Madre)* Father *(Padre)* Sister *(Hermana)* Brother *(Hermano)* randparent Maternal/Paternal *(Abuelos Maternos/Paternos)*

CENTRAL FLORIDA VEIN & VASCULAR CENTER

Name *(Paciente)*:_____ **DOB** *(Fecha de Nacimiento):* _____

SOCIAL HISTORY *(Historia Social)*

☐ **Alcohol Use** *(Uso de Alcohol)*	_ Drink(s) per day *(Bebidas por día)* _ Drink(s) per week *(Bebidas a la semana)*
Drug Use (*Uso de Drogas)*	ype *(Tipo)*:
Physical Disabilities (*Desabilidad Fisica)*	Unable to Stand *(Incapaz de pararse)* ☐ Do Not Walk *(No puedes andar)* ☐ Unable to Walk more than_____ feet *(No puedes andar mas de_____pies)* ☐ Severe breathing problems *(Problemas Respiratorios Severos)* Oxygen Dependant *(Dependiente de oxígeno)*
Exercise Habits (*Ejercicios)*	☐ Walk *(Andar)* Work out *(Ejercicio)* ☐ Daily *(Diario)* ☐ Weekly *(Semanal)* ☐ Biweekly *(Quincenal)* Other *(Otro)* _____
Difficulty Understanding English (*Dificultad Entendiendo Ingles)*	ative Language *(Lenguaje de Nacionalidad)*:
Homebound *(Restringida o en la Casa)*	am homebound and unable to leave home unassisted. *Estoy restrigido y no puedo salir de mi casa.)*
Significant Other *(Tienes Pareja)*	am living with a significant other. *Yo estoy viviendo con mi pareja.)*
Assisted Living Facility *(Facilidad de vivienda asistide)*	am living in an Assisted Living Facility. *Yo estoy viviendo en una facilidad de vivienda asistida.)*
Skilled Nursing Facility *(Ancianato)*	am living in a Skilled Nursing Facility. *Yo estoy viviendo en un Ancianato/Asilo de Ancianos)*
Home Environment *(Ambiente del hogar)*	am living in a secure/supportive home environment. *Yo estoy viviendo en un hogar con ambiente seguro.)*
Caregiver *(Cuidador)*	have a caregiver. *Yo tengo una persona que me cuida.)*
Powers of Attorney *(Poder de Potestad)*	have assigned powers of attorney to *Yo he firmado un poder de potestad.)*

Name *(Paciente)*:_____ **DOB** *(Fecha de Nacimiento:* _____

MEDICATIONS *(Medicamentos)*

		Frequency *(Frecuencia)*			
Medication Name *(Medicamentos)*	**Strength** *(Milligramos)*	**Once Daily** *(Una Diario)*	**Two times Daily** *(Dos veces al día)*	**Every____hours** *(Cada____Horas)*	**Other** *(Otra)*
				_____hours/horas	
				_____hours/horas	
				_____hours/horas	
				_____hours/horas	
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				_____hours/horas	
				_____hours/horas	

ALLERGIES *(Alergias)*

☐ **No Known Allergies *(Alergias Conocidas)***
Are you allergic to ☐ **latex** or to ☐ **iodine**?

	Type of Reaction *(Tipo de Reacion)*				
Allergy *(Alergias)*	**Rash** *(Alergia en la Piel)*	**Nausea Vomiting** *(Nausea Vomitos)*	**Difficulty Breathing** *(Dificultad para respirar)*	**Coma** *(Coma)*	**Other** *(Otra)*
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Name *(Paciente)*: _____ **DOB** *(Fecha de Nacimiento:* _____

Vein Health Questionnaire

Pregnancy Related Vein History:

During your pregnancy did you experience:

- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Leg Heaviness/Tiredness
- ☐ Painful Varicose Veins
- ☐ Labial Varicose Veins
- ☐ Phlebitis
- ☐ Deep Vein Thrombosis
- ☐ Skin Discoloration
- ☐ Restless Legs
- ☐ Throbbing/Tingling
- ☐ Itching
- ☐ Painful Bulging Veins
- ☐ Leg Numbness
- ☐ Lower Extremity Ulcers/Wounds
- ☐ Dermatitis
- ☐ Spider Veins

Current Symptoms:

Do you currently experience any of the following:

- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Leg Heaviness/Tiredness
- ☐ Painful Varicose Veins
- ☐ Labial Varicose Veins
- ☐ Phlebitis
- ☐ Deep Vein Thrombosis
- ☐ Skin Discoloration
- ☐ Restless Legs
- ☐ Throbbing/Tingling
- ☐ Itching
- ☐ Painful Bulging Veins
- ☐ Leg Numbness
- ☐ Lower Extremity Ulcers/Wounds
- ☐ Dermatitis