O'DONNELL
vein & laser

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ______________

Home Phone: ____________ Cell Phone: ______________ Work Phone: ____________

Email Address: ____

Home Address: ______________________ City: ________ State_____ ZIP: ______

Social Security #: ________________ Marital Status: Single Married Divorced Widowed

Emergency Contact: ______________________ Phone: ______________

Primary Care Physician: ______________________ Phone: ______________

Referring Physician: ______________________ Phone: ______________

How did you hear about us?: ________________________________

HIPPA Choices:

Did you receive a copy of the HIPAA notice? YES _____ NO _____ Allow Voice Msg? YES _____ NO _____

Allow SMS (text message)? YES _____ NO _____ Allow postal mail? YES _____ NO _____

Occupation: ________________ Employer: ______________________

Language: ____________ Race/Ethnicity: ______________

Primary Health Insurance Name: ______________________ ID#: ______________

Group #: ______________ Subscriber: Self _______ Spouse _______ Other __________

Subscriber's Name: ______________________________ DOB: ______________

Secondary Health Insurance Name: ______________________ ID#: ______________

Group #: ______________ Subscriber: Self _______ Spouse _______ Other __________

Subscriber's Name: ______________________________ DOB: ______________

Patient Name: ____

Height: _____'_____" Weight: ___________ Gender: Male Female

Reason for Visit: ____

Chief Complaint:

____Aching
____Awakened at night
____Bleeding from veins
____Burning
____Cramping
____Diff. healing wounds
____Fatigue
____Heaviness
____Itching
____Pain
____Restless legs
____Swelling
____Ulcers
____Varicose veins
____Spider veins
____Skin discoloration
Other: ________________
____

Which Leg: Right Left Both How long: ___________________________

Ulcer on Leg: No Yes: which leg? _____________ for how long? ______________________

Timing of Symptoms: ____Intermittently ____Mostly at night ____Only during daytime

____All day ____While laying down ____Bedtime ____Other: ______________

How do these symptoms affect your activities of daily living?

Work: ____
Daily Chores: ____
Care for Family: ____
Travel: ____
Walking/Exercising: ____
Other: ____

Symptoms made worse by:

____Walking ____Exercise____Prolonged Standing ____Prolonged Sitting ____Leg Elevation ____Heat
____Premenstrual ____Pregnancy ____Travel ____Other: _________________________

Symptoms made better by:

____Resting: how often? ______________ ____Leg Elevation ____Standing ____Sitting
____Walking ____Exercise ____ Heat ____Other: ________________________________

Conservative Therapy: (please check any of the conservative therapy measures you have tried)

____Compression Stockings ____Elevation ____Weight Reduction ____Exercise
____Avoiding Prolonged Sitting/Standing ____Tylenol/Motrin ____Other: __________________

How long have you been using conservative measures? ________________________________

Vein History

Past Vein Procedures:

____

____

Past Vein History: ____DVT ____PAD ____Leg Ulcers Other: ____________________

Are you on any blood thinners? YES NO If yes, what? ______________________________

Past Medical History:

____CAD ____High Cholesterol ____High Blood Pressure ____Gout ____Diabetes ____CHF

____HIV/AIDs ____Hepatitis ____Mental Health Disorder ____Neuropathy (Peripheral)

____Hypothyroidism ____Peripheral Vascular Disease Other: ______________________________

Past Surgeries:

____

____

____

Family History:____Venous Disease ____Clotting Disorder ____Stroke

____Diabetes ____Hypertension ____Cancer Other: ________________________

Social History: Alcohol: ____Never ____Rare ____Occasional ____Daily

Smoking: ____Never ____Current Smoker

____Quit >1 year ____Quit 1-10 years ____Quit 10+ years

Female History: ____#pregnancies ____planning for pregnancy

Allergies:

____

____

____

Current Medications:

____

____

____

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Review of Systems: (please check all that apply)

Constitutional:
____ Fatigue
____ Fever
____Recent weight loss
____Recent weight gain

Cardiovascular:
____Chest pain
____Palpitations
____Shortness of Breath
    ____with walking
    ____while lying flat
____Swelling legs/ankles
____Varicose veins

Respiratory:
____Chronic/Freq cough
____Cough/spit up blood
____Wheezing
____Asthma

Gastrointestinal:
____Abdominal Pain
____Black tarry stools
____Changes in bowel habits
____Difficulty/Pain swallowing
____Heartburn
____Hemorrhoids
____Indigestion
____Jaundice
____Pain on defecation
____Rectal bleeding
____Vomiting of blood

Genitourinary:
____ Blood in urine
____ Difficulty urinating
____Irregular/abnormal periods
____Pain or burning with urination
____Pain with intercourse
____Pain with menstruation
____Pelvic pain
____Vulvar veins

Musculoskeletal:
____Ankle pain
____Back pain
____Foot pain
____Hip pain
____Knee pain
____Leg cramps

Integumentary:
____Easy skin bruising
____Eczema
____Hair loss
____Heavy sweating
____Itching
____Rashes
____Skin lesions
____Ulcers

Endocrine:
____Cold intolerance
____Excessive thirst
____Excessive urination
____Heatintolerance
____Incontinence

Hematologic/Lymphatic:
____Bleeding tendencies
____Enlarged lymph nodes

ASSIGNMENT OF BENEFITS FORM

I, ____, understand that services rendered to me by O'Donnell Vein and Laser/Kelly O'Donnell, M.D. are my financial responsibility and that the provider will bill my insurance company. I authorize my insurance company to pay my benefit directly to O'Donnell Vein and Laser/Kelly O'Donnell, M.D. and I understand that I will be responsible for any amount allowed and not paid by my insurance company. I am also responsible for any Deductible, Copay and/or Co-insurance.

I authorize the provider to release any information necessary to adjudicate my claims.

I also understand that should my insurance company send payment directly to me, I will forward the payment to the office in a timely manner.

I certify that the information I have provided with regard to my insurance coverage is current and correct. I agree to continually provide current and accurate health insurance information should any changes occur. I agree to notify the office of any updated insurance information prior to any services being rendered.

I authorize O'Donnell Vein and Laser/Kelly O'Donnell, M.D. to initiate a complaint or file an appeal to my insurance company and/or the insurance commissioner on my behalf and I personally will be active in the resolution of any claim delays, unjustified reductions or denials.

Patient Signature: ____ Date: __________________

Parent or Guardian Signature: ______________________________ Date: __________________

COLLECTION AGREEMENT

If payment is not made as agreed, I will be responsible for all court costs, 35% collection fees and attorney fees.

Patient Signature: ____ Date: __________________

Parent or Guardian Signature: ______________________________ Date: __________________

Quality of Life Questionnaire

Patient: ______________________________ Date: ____________________

For each symptom, sensation or discomfort listed, please answer the corresponding question.
Please circle the right answer.

In the past four weeks, you have felt pain in the ankles or legs, what was the intensity of this pain?

NO PAIN	LIGHT PAIN	MODERATE PAIN	STRONG PAIN	INTENSE PAIN
1	2	3	4	5

During the past four weeks, to what extent did you feel bothered/limited in your work or your other daily activities because of your leg problem?

NOT LIMITED/BOTHERED	A LITTLE LIMITED/BOTHERED	MODERATELY LIMITED/BOTHERED	VERY LIMITED/BOTHERED	EXTREMELY LIMITED/BOTHERED
1	2	3	4	5

During the past four weeks, did you sleep badly because of your leg problems, and how often?

NEVER	SELDOM	OFTEN	VERY OFTEN	EVERY NIGHT
1	2	3	4	5

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During the past four weeks, to what extent did your leg problems bother/limit you while doing the movements or activities listed below?

	Not Bothered/ Limited at All	A Little Bothered/ Limited	Moderately Bothered/ Limited	Very Bothered/ Limited	Impossible to do
To stand for a long time	1	2	3	4	5
To climb stairs	1	2	3	4	5
To crouch or kneel	1	2	3	4	5
To walk briskly	1	2	3	4	5
To travel by car, bus, plane	1	2	3	4	5
To do housework such as standing in kitchen, carrying a child in your arms, cleaning floors or furniture, doing handy work	1	2	3	4	5
To go to discos, weddings, parties, cocktails	1	2	3	4	5
To play a sport, to make physically strenuous efforts	1	2	3	4	5

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

	Not at all	A little	Moderately	A lot	Absolutely
I feel on edge	1	2	3	4	5
I become tired quickly	1	2	3	4	5
I feel I am a burden to people	1	2	3	4	5
I must always take precaution (such as to stretch my legs, to avoid standing for a long time...)	1	2	3	4	5
I am embarrassed to show my legs	1	2	3	4	5
I get irritated easily	1	2	3	4	5
I feel handicapped	1	2	3	4	5
I have difficulty getting going in the morning	1	2	3	4	5
I do not feel like going out	1	2	3	4	5

Optional Cosmetic Interest Form

Please select any skin concerns you are interested in learning more about:

- ☐ Fine Lines/Wrinkles
- ☐ Sun Damage (Hands/Arms)
- ☐ Brown Spots/Pigmentation
- ☐ Red Spots/Facial Veins
- ☐ Uneven Skin Tone
- ☐ Unwanted Facial/Body Hair
- ☐ Spider Veins
- ☐ Scars
- ☐ Double Chin
- ☐ Acne
- ☐ Flat Cheeks/Mid-face Volume Loss
- ☐ Lips: Shape/Fullness
- ☐ Skin Texture
- ☐ Large Pores
- ☐ Loose Skin
- ☐ Permanent Fat Reduction/ Body Contouring

Share with us any other areas of concerns:

____

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