Interventional and Vascular Care

12840 Hillcrest Rd., #E104
Dallas, Tx 75230
Ph: 469-828-6166

Patient Information (Informacion al Paciente)

Date (Fecha): _____

Last Name (Apellido): _____ **First Name**(Nombre):_____

Address (Direccion): _____

City/State/Zip (Ciudad/Estado/Codigo postal): _____

DOB (Fecha De Nacimento): _____ **Age** (Edad): _____ **Sex** (Sexo): **M** **F** SSN: _____

Marital Status (Estado civil): _____ **Race/Ethnicity** (Raza/Etnicidad): _____

Language (Idioma): _____ **Email Address** (Correo electronico): _____

Home Phone (Telefono del hogar): _____

Cell Phone (Telefono cellular): _____

Employer (Empleador): _____ Occupation (Ocupacion): _____

Employment status (Estatus laboral): _____

Emergency Contact (Contacto de emergencia): _____ Relationship (Relacion): _____

Emergency Contact Phone (Telefono de contacto de emergencia): _____

If Patient is a minor (Si el paciente es menor de edad):

Guardian's Name (Nombre del Guardian): _____ **DOB:** _____

SSN: _____

Primary Care Physician (Medico de atencion Primaria): _____ **Phone** (Telefono):
_____

Referring Physician (Medico de referencia): _____ **Phone** (Telefono):
_____

If not a referring physician, who referred you to our practice (Si no es un medico de referencia quien lo referio a nuestra practica):
_____

Pharmacy (Farmacia): _____ **City** (Ciudad): _____ **Phone** (Telefono): _____

Interventional and Vascular Care
Insurance Information (Informacion del Seguro)

Primary Ins (Aseguranza Principal): _____ **Address** (Direccion): _____

Primary Ins Phone (Telefono de Aseguranza): _____ **Insured's Name** (Nombre del asegurado): _____

DOB: _____ **SSN** _____ **Insured's ID** (ID# de asegurado): _____

Group# (Grupo #): _____ **Relation** (Relacion): _____

Secondary Ins (Asesuranza Secundaria): _____ **Address** (Direccion):
_____

Phone (telefono): _____**Insured's Name** (Nombre del Asegurado):
_____

DOB: _____ SSN _____ **Insured's ID#** (ID# de asegurado): _____

Group# (Grupo #): _____ **Relation** (Relacion): _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed Insurance Company (ies) and assign directly to Interventional and Vascular Care, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ **Relationship** _____

Date _____

Asignación y liberación
Yo, el abajo firmante, certifico que yo (o mi dependiente) temenos cobertura de seguro con la (s) compañía (s) de seguros mencionada anteriormente y le asigno directamente a intervencional y vascular Care, Inc. todos los beneficios de seguro, si los hubiere, de lo contrario pagadero a mí por los servicios prestados. Entiendo que soy financieramente responsable de todos los cargos que sean o no pagados por el seguro; Por la presente autorizo al doctor a que libere toda la información necesaria para asegurar el pago de los beneficios. Autorizo el uso de esta firma en todas las presentaciones de seguros.

Firma del Partido responsable:_____**Relacion**: _____

Fecha: _____

Interventional and Vascular Care
FINANCIAL POLICY

We are dedicated to providing you with quality medical care. In order to achieve this goal we require you have a complete understanding of not only our need for a complete medical history, but also the financial policies of this office.

We will file Medicare and most secondary insurances. However, you must present us with complete and accurate information.

We will verify your insurance coverage prior to your visit and file your HMO or PPO. You will be responsible for making your co-payments, deductible and co-insurance at the time of your visit.

For our surgical patient, you will be contacted by this office prior to your surgery and advised of any amount you will owe. Payment is expected prior to your surgery date.

If for any reason your insurance claims are pended for information that must be received from you and you have not responded to your carrier within their allotted time frame you will be responsible for the balance in full. Examples of these situations are claims pended for accident details, coordination of benefit or a child's student status.

We will be happy to complete Disability forms or FMLA paper work. This process usually takes from two to three weeks. The cost is $25 per form. Completed paperwork must be picked up from our office, at which time the $25 fee will be collected. We will not fax these forms, they must be picked up.

We appreciate your cooperation. If you should have questions, please feel free to discuss them with the staff.

I have read and received a copy of the above financial policy of Interventional and Vascular Care, Inc.

Responsible Party's Name (Print): _____

Responsible Party's Signature: _____ Date: _____

Interventional and Vascular Care

12840 Hillcrest Rd., #E104
Dallas, Tx 75230
Ph: 469-828-6166

NOTICE OF PRIVACY POLICIES AND PRACTICES

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

INTRODUCTION

At Interventional and Vascular Care, Inc., we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2013 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit Interventional and Vascular Care, Inc., a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source of medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your medical record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Interventional and Vascular Care, Inc. is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodates reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use of disclose your health information after we have receive a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION:

We will use your health information for treatment: Your health information may be used by staff members of disclosed to other health care professions for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available to your medical record to all health professionals who may provide treatment or who may be consulted.
We will use your information for payment: Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.
We will use your information for regular health operations: Your health information may be used as necessary to support the day-to-day activities and management of INTERVENTIONAL AND VASCULAR CARE, INC. For

example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: In some instances, we have contracted sepaP8 rate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be billing service, collection agency, answering services and computer software/hardware provider.

Communication with family: Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive our information.

Research/Teaching/Training: We may use your information for the purpose of research, teaching and training.

Healthcare Oversight: Federal law requires us to release your information to an appropriate health agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting: Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminder: The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or a brief non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods please inform the practice.

Other uses and disclosures: Disclosure of your health information or its use for any purpose other than those listed about requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of INTERVENTIONAL AND VASCULAR CARE, INC. please contact:

Kelly Phariss
INTERVENTIONAL AND VASCULAR CARE, INC.
12840 Hillcrest Rd., #E104
Dallas, Tx 75230
Ph: 469-828-6166

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below.

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Service
200 Independence Avenue, S.W., Room 509F, HHH Building
Washington, D.C. 20201

Acknowledgement of Receipt of
Notice of Privacy Practices

I have received the Notice of Privacy Practices of Interventional and Vascular Care, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my records.

_____ _____

Signature of Patient **Date**
Or Personal Representative

_____

Printed Name of Above Signature

_____

Relation to Patient if Signed by Representative

_____

Interventional and Vascular Care Witness

Interventional and Vascular Care
Privacy Information (Informacion de Privacidad)

Patient Name (Nombre del paciente): _____

1. **Please list the names of family members or other persons, if any, who we may inform about your general medical condition and your diagnosis** (Por favor liste los nombres de los miembros de la familia o otras personas, en su casa, a quienes podamos informar sobre su condicion medica general y su diagnostico):

   _____

2. **Please list the names and phone numbers of family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY** (Por favor liste los nombres y numeros de telefono de los miembros de la familia o otros significativos, a quienes podamos informar sobre su condicion medica Solo en caso de emergencia):

   _____

3. **Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home** (Por favor anote la direccion de donde desea que sus Estatdo de Cuenta y/o correspondencia de nuestra oficina sean enviados si no es su casa):

   _____

4. **Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"** (Infique si desea que toda la correspondencia de nuestra oficina sea enviada en un sobre sellado y marcado como "confidencial":

   Yes (Si) No

5. **Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home number** (Por Favor anote el numero de telefono, si lo hay, donde desea recibir llamadas sobre sus citas, resultados de laboratorio y rayos x, otra informacion de atencion medica si no es su numero de casa): _____

6. **Can confidential messages (i.e. appointment reminders) be left on your home answering machine or** voicemail (Puedo dejar mensajes confidenciales (es decir, recordatorios de citas) en su contestador automatico o buzon de voz)?

   Yes (Si) No

7. **If you do not have voicemail, can a confidential message be left at your place of employment** (Si no tiene buzón de voz, (puede dejar un mensaje confidencial en su lugar de trabajo)?

   Yes (Si) No

Patient/Guardian signature (Paciente/Guardian Firma): _____ **Date** (Fecha): _____

By my signature below, I acknowledge that I have received the NOTICE OF PRIVACY POLICIES AND PRACTICES for Interventional and Vascular Care, Inc. (Por mi firma a continuación, reconozco que he recibido el aviso de políticas de privacidad y prácticas para intervencional y vascular Care, Inc.)

Patient/Guardian signature (Firma del paciente/guardian): _____**Date** (Fecha):_____

Interventional and Vascular Care
Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (HER/EMR) and becomes art of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medication in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies hat patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medications to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Interventional and Vascular Care
BENEFIT ASSIGNMENT RECORD RELEASE PAYMENT AGREEMENT

This agreement is entered into this date by and between hereinafter called "Patient" and Interventional and Vascular Care, hereinafter "Provider".

Whereas Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for payment of such benefits, it is hereby agreed:

SECTION 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider.

> This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of patient assignment of benefits is a convenience to Patient and that Provider may revoke this assignment at any time.

SECTION 2. Patient thereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payment for the healthcare services rendered by Provider directly to Provider.

SECTION 3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

SECTION 4. Patient agrees that in the event Patient receives any check, draft or other payment subject to this Agreement, patient will act as a fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft or payment to Patient's debt for services rendered.

SECTION 5. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by the Patient/insured or be mailed to a designated address.

SECTION 6. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or healthcare plan. Patient further agrees to pay for any services not covered by Patient's insurance or healthcare plan. A refund, if any, will be calculated upon receipt of payment from your insurance company.

SECTION 7. In the event that any Section or provision of this Agreement is legally void, invalid or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

IN WITNESS THEREOF, this agreement has been explained to the (patient's) satisfaction and having due knowledge and understanding entered into the day and year set forth below.

_____ _____
Patient Date

_____ _____
Guardian (If patient is a minor) Date

_____ _____
Witness Date

Interventional and Vascular Care
Confidential Health History

Name (Nombre): _____ **Date** (Fecha): _____

Reason for your visit (Motivo de su visita): _____

Family Medical History (Historia Médica Familiar)

	Mother (Madre)	**Father** (Padre)	**Siblings** (Hermanos)
Age (Edad)			
Alive (Vivo)			
Deceased (Difuntos)			
Back problems (Problemas de espalda)			
Diabetes			
Heart Disease (Enfermedad cardiaca)			
Stroke (Ataque)			
Thyroid (Tiroides)			
High blood pressure (Presion alta)			
Lung Disease (Enfermedad pulmonar)			
Cirrhosis (Cirrosis)			
Cancer			
Other/Otro			

Social History (Historia Social)

Tobacco	Y	N	**# packs/day** (paquetes al Dia)
Caffeine	Y	N	**Cups per Day** Copas al Dia
Alcohol	Y	N	**Drinks per week** Bebidas por semana

ALLERGIES/ALLERGIAS:

Are you allergic to any medications? Yes / No If so, please list:
(Es usted Allergico a algun Medicamento?) Si/No (Si es asi Porfavor Enumere?)

Have you had a reaction to X-ray dye? Yes / No
(Ha tenido una reaccion al tinte de Rayos X?) Si/No

Are you allergic to iodine or shellfish? Yes / No
(**Eres alergico al yodo o a los Mariscos**?) Si/No

Are you allergic to Latex? Yes / No
(Eres alergico al Latex?)

Patient Medical History: Please circle if you have ever had any of the following conditions.
Historial Medica del Paciente:

Diabetes	Y (Si)	No
High blood pressure (Alta Pression)	Y (Si)	No
Liver Disease (Enfermedad hepatica)	Y (Si)	No
Heart Disease (Enfermedad Cardiaca)	Y (Si)	No
Kidney disease (Enfermedad Renal)	Y (Si)	No
Pulmonary Emboli (Embolos pulmonar)	Y (Si)	No
Blood clots/DVT (Coagulos sanguineos, TVO)	Y (Si)	No
Seizures (Convulsiones)	Y (Si)	No
Stroke (Ataque)	Y (Si)	No
Bleeding Disorders	Y (Si)	No
Pregnancies (Embarazos)	Y (Si)	No
Other/Otro	Y (Si)	No

Vascular History:
(Historia Vascular)

Varicose Veins (Varices)	Y (Si)	N	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Phlebitis (Flebitis)	Y (Si)	N	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**When?** (Cuando?)

Blood Clots (DVT) (Coagulos de Sangre)	Y (Si)	N	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**When?** (Cuando?)
Spontaneous Rupture or Bleed (Ruptura espontenea O sangrado)	Y (Si)	N	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**When?** (Cuando?)
Leg Ulcerations (Non-healing wounds) (Ulceraciones de las pierna)	Y (Si)	N	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**When?** (Cuando?)
Worn Compression Stockings (20-30 mmHg) (Medias de compression desgastadas 20-30mmHg)	Y (Si)	N	**How long?** (Cuanto Tiempo?)		**Ordered By:** (Ordenado Por:)
Do you elevate your legs to reduce leg pain? (Eleva laspiernas paras edmcir el dolor en las pierras)	Y(Si)	N	**How many hours?** (Cuantas horas?)		
Do let symptoms effect any of the following? (Los Simptomas en las Piernas afectan cualquiera de los Siguientes?)	Exercising (Ejercisioo) Walking(Para Caminar) Standing (En Pie) Sitting (Sentado) Driving (Manejando) Working (Trabajando) Household chores (Tareas Domesticas)				
Exercise Regular (ejercicio regular)	Y (Si)	N	**How many times a week?** (Cuantas veces a la semana?)		
Stand for long periods of time? (Reposa durante largos periodos de tiempo)	Y (Si)	N	**How long?** (Cuanto Tiempo?)		
Hormone Replacement Therapy/Birth Control Pills? (Terapia de reemplazo hormona/pildores anticonceptivas)	Y (Si)	N	**How long?** (Cuanto Tiempo?)		

Family Vascular History (Historia Vascular Famillar):

Spider Veins (venas de arana)	**None** (Ninguno)	**Mom** (Madre)	**Dad** (Padre)	**Siblings** (Hermanos/as)	**Grandparents** (Abuelos)
Varicose Veins (Venas Varicosas)	**None** (Ninguno)	**Mom** (Madre)	**Dad** (Padre)	**Siblings** (Hermanos/as)	**Grandparents** (Abuelos)
Leg Swelling (Hinchazon de la pierna)	**None** (Ninguno)	**Mom** (Madre)	**Dad** (Padre)	**Siblings** (Hermanos/as)	**Grandparents** (Abuelos)
Leg Ulcers (Ulceras en las piernas)	**None** (Ninguno)	**Mom** (Madre)	**Dad** (Padre)	**Siblings** (Hermanos/as)	**Grandparents** (Abuelos)
Blood Clots (Coagulos de sangre)	**None** (Ninguno)	**Mom** (Madre)	**Dad** (Padre)	**Siblings** (Hermanos/as)	**Grandparents** (Abuelos)

Vascular Symptoms (Sintomes Vasculares):

Aching/Pain (Dolor)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Swelling (Hinchazon)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** Cuanto Tiempo?)
Heaviness (Pesadez)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Tired/Fatigued (Cansado/a Fatigado/a)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Itching/Burning (Picazon/ ardor)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Cramps (Calambres)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Restless leg (Pierna inquieta)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Throbbing (Palpitante)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Skin Discoloration (Descoloracion de la piel)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)
Spider veins (Cirugias Vasculares pasadas)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**How long?** (Cuanto Tiempo?)

Past Vascular Surgeries (Cirugias Vasculores Pasadas): Please circle if you have ever had any of the following conditions.

Vein Sclerotherapy (Esclerotherapia de venas)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	**Date** (Fecha)
Vein Phlebectomy (Flebectomia Venosa)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	

Vein Ablation (Ablacion de vena)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	
Vein Ligation (Ligadura de vena)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	
Vein Stripping (Extraccion de venas)	Y (Si)	No	**LT leg** ISQUIERDA Pierna	**RT leg** DERECHA Pierna	

Hospitalizations (Hospitalizaciones):

_____
_____
_____
_____
_____

Review of Systems (Revision de los Sintomas):

GENERAL (General)			**RESPIRATORY (Respiratorio)**		
Lack of energy (Falta de energia)	Y (Si)	No	**Shortness of breath** (Falta de aliento)	Y (Si)	No
Unexplained weight gain or loss (Ganancia o Perdida de peso inexplicable)	Y (Si)	No	**Night sweats** (Sudores nocturros)	Y (Si)	No
Loss of appetite (Perdida de apetito)	Y (Si)	No	**Prolonged cough** (Tos prolongada)	Y (Si)	No
Fever (Fiebre)	Y (Si)	No	**Wheezing** (Sibilancias)	Y (Si)	No
Night sweats (Sudores Nocturnos)	Y (Si)	No	**Pleurisy** (Pleuresia)	Y (Si)	No
Other (Otro)	Y (Si)	No	**Coughing up blood** (Tosiendo sangre)	Y (Si)	No
EARS, NOSE, MOUTH & THROAT (Oidos, nariz, boca & garganta)			**Other** (Otro)	Y (Si)	No
Difficulty with hearing (difilcultad para escuchar)	Y (Si)	No	**GI (GASTROINTESTINAL)**		
Sinus problems (problemas de sinusitis)	Y (Si)	No	**Heartburn** (agruras)	Y (Si)	No
Runny nose (nariz que moquea)	Y (Si)	No	**Constipation** (Estrenimiento)	Y (Si)	No
Ringing in ears (zumbido en los oidos)	Y (Si)	No	**Diarrhea** (Diarrea)	Y (Si)	No
Nosebleeds (hemoragias nasales)	Y (Si)	No	**Abdominal pain** (Dolor Abdominal)	Y (Si)	No
Sore throat (dolor de garganta)	Y (Si)	No	**Difficulty swallowing** (Difilcultad para tragar)	Y (Si)	No

Other (otro)	Y (Si)	No	**Blood in stools** (sangre en el escremento)	Y (Si)	No
HEART & BLOOD VESSELS (Corazon y vasos)			**Other** (otro)	Y (Si)	No
Irregular heartbeat (latido del Corazon irregular)	Y (Si)	No	**GU (KIDNEY & BLADDER) (Rinones y vejiga)**		
Racing heart latidos rapidos)	Y (Si)	No	**Painful urination** (dolor al orinar)	Y (Si)	No
Chest pains (Dolor de pecho)	Y (Si)	No	**Frequent urination** (orinar frecuentemente)	Y (Si)	No
Swelling of feet or legs (hinchazon de pies o piernas)	Y (Si)	No	**Urgency** (urgencia)	Y (Si)	No
Pain in legs with walking (dolores en las piernas)	Y (Si)	No	**Prostate problems** (problemas de la Prostata)	Y (Si)	No
Other (Otro)	Y (Si)	No	**Other** Otro)	Y (Si)	No
MS (MUSCLE, BONES, JOINTS) (Musculos, guesos, articulaciones)			**INTEG (SKIN, HAIR & BREAST (Piel, cabello, cenos)**		
Joint pain (Dolor en las Articulaciones)	Y (Si)	No	Persistent rash (erupcion persistente)	Y (Si)	No
Aching muscles (dolor muscular)	Y (Si)	No	Itching comezon)	Y (Si) (Si)	No
Shoulder pain (Dolor de hombro)	Y (Si)	No	New skin lesion (Nueva lesion de piel)	Y (Si)	No
Swelling of joints (Hinchazon de las Articulaciones)	Y (Si)	No	Hair loss (Perdida de cabello)	Y (Si)	No
Other (Otro)	Y (Si)	No	Other (Otro)	Y (Si)	No

Please list current medication (por favor de numerar los medicamentos):

Medication (Medicacion	Dose (dosis)	Quantity/Frequency (Cantidad/frecuencia)

Patient name (nombre del Paciente): _____

Patient/Guardian Signature (Paciente/Guardian firma): _____ **Date** (fecha): _____