Sreenivas G. Reddy, MD
Vascular and Interventional Radiology
7 N. Grant Street 1st Floor
Hinsdale, Il 60521

Phone: 708-354-8881
Fax: 708-354-8340
www.ChicagoLegs.com

I,______________________ to the best of my knowledge have not been exposed to anyone with Covid-19 nor do I present any cold or flu symptoms.

I have taken all precautions and have been keeping social distance to the best of my ability.

Vein and Vascular Centers, SC is taking every precaution to keep our patients safe in our clinics by using masks, gloves and thoroughly sanitizing.

____

(Patient Print Name)

____

(Patient Signature)

_____/____/2022

(Date)

Temperature:

____

(Staff Signature)

Name: ______________________________Age:________Sex: M F Date:_____________.

Contact Phone:______________________________________Date of Birth:__________________.

Address____

City ___________________________ State ____ Zip Code ____________________________

Cell Phone ______________________ Email ___________________________@__________________

Spouse's Name ____________________________________ Spouse's DOB ____________________

Emergency Contact ______________________Phone ________________ Relationship _________

Primary Insurance _____________________Secondary Insurance __________________________

Primary Doctor _______________________ How did you hear about us? _____________________

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VEIN AND VASCULAR CENTERS, SC

The reason why you are here today

____
____
____
____.

History of Present Illness

Where is the pain and or problem? ____

How severe is the pain/problem? 5 being most severe ________________________________

When does this pain/problem occur? ____

How long have you had this pain/problem? _______________________________________

What other symptoms are you having? ____

Current Medical History

1. Do you experience any of the following in your legs:

Symptom	Yes	No
• Aching/pain		
• Heaviness		
• Tiredness/fatigue		
• Itching/burning		
• Swollen ankles		
• Leg cramps		
• Restless legs		
• Other		
• Throbbing		

2. Have your veins gotten worse in recent months Yes No
3. Do you elevate your legs to relieve discomfort? Yes No
4. Do you wear support hose prescribed by a doctor Yes No
   If yes, what type?________________________
5. Do you wear light support hose (e.g. sheer energy)? Yes No
6. Do they provide relief? …………. Yes No
7. Do you have any problems walking? Yes No
   If yes, how does it affect you? _______________
8. Do you stand much at work? ………… Yes No
   at home? …… Yes No
9. How does this standing affect your legs?
   ____
10. Have you ever had your veins evaluated before? Yes No
    If so, when and where?____________________
11. Have you ever had any test(s) done on your veins? Yes No
    When and where ___________________________

Family History

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

Father ………Yes No Mother …….. Yes No
Brother………Yes No Sister………..Yes No

Medications

1. Do you have any allergies (medicines, food, pollen, shrimp or shellfish, iodine IVP dye?) Yes No
Please list them and briefly describe your reaction (e.g. rash, hives, shortness of breath, etc.)

____
____
____

2. Are you presently taking any medication including prescription and/ or non-prescription for your leg pain? (Over-the-counter) medicines Yes No

3. Do you take any blood-thinning medication?
Yes No

4. Are you taking hormones or birth control pills?
Yes No

Please list any and all medications that your are currently taking.

____
____
____
____
____
____

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VEIN AND VASCULAR CENTERS, SC

	Yes	No
1. Have you ever been in the hospital as a patient. If yes, for what reason		
If yes, for what reason		
2. Have you ever had surgery? If yes, for what reason		
3. Have you ever had vein stripping surgery. If yes, when and which leg?		
4. Have you ever had vein injections? If yes, when, where, and which leg?		
5. Are you presently under the care of a physician? If yes, for what illness or purpose?		
6. Have you ever had a blood clot? If yes, which leg and when?		
7. Have you ever had phlebitis? If yes, which leg and when?		

Women Only: Are you …	**Yes**	**No**
Pregnant or think you may be?		
Nursing (breast-feeding)?		
Taking oral contraceptives?		
Taking hormone replacements?		

Past Medical History

Do you have or have you had any of the following problems?

High Blood Pressure	Yes	No
Cardiac Pacemaker, Heart Disease/ Murmur		
Rheumatic Fever		
Leg Ulcers		
Stroke		
Diabetes		
HIV Infection		
Glaucoma/ Eye problems		
Stomach /Bowel Problem/ GI		
Recent Weight Loss		
Keloids/excessive scar		
Birth Defects		
Arthritis / Gout / Artificial Joints		
Bleeding Tendency/Anemia		
Cancer		
Liver disease or hepatitis		
Hay Fever/Allergies		
Seizures, Ears, Nose, Throat, Neurologic		
Kidney/Bladder Problem		
Asthma or Lung Problems		
Thyroid		

Social History: Please Circle

Marital status: Single Married Divorced

Widowed Separated

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously, but quit:

_____ Current packs/day _____

Patient Name: ___________________________

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Vein and Vascular Centers, SC

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<u>Vein and Vascular Centers Notice of Privacy Practices</u>

WHAT IS THIS NOTICE OF PRIVACY PRACTICES?

This notice describes ways in which your medical information may be used and disclosed. This notice also explains *your* rights and the obligations *we* have regarding the use and disclosure of medical information. This notice applies to ALL of your records generated and used by Vein and Vascular Centers, whether made by the practice or another facility. This notice describes our policies which extend to all areas of our practice, all who work for or with our practice, and any business associates involved in the handling of your medical information. Please review carefully.

YOUR PERSONAL MEDICAL INFORMATION - "PROTECTED HEALTH INFORMATION" (PHI)

Your medical/health information is personal, and we are committed to protecting the information about you. At Vein and Vascular Centers, we create paper and electronic records of the care and services/items you receive at our office. We must keep such records to provide you with quality care and to comply with certain legal requirements.

OUR OBLIGATIONS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

By law, we are required to:

- Make sure that your protected health information (PHI) is kept private;
- Provide you with our Notice of Privacy Practices that details how we use and disclose your PHI;
- Advise you of the laws about PHI and your legal rights with respect to your PHI;
- Follow the conditions of the notice that is currently in effect.

Changes to this Notice: We reserve the right to change this notice at any time. We will always have a copy of the current notice available in the office. The notice will contain the date of last revision and effective date on the first page (top right hand corner). Each time you visit the office you may request a copy of the current notice in effect.

Handling of Protected Health Information (PHI): This notice will detail how the law allows us to use and disclose your PHI. Other uses and disclosures of PHI *not* covered by this notice or the laws that apply to us will be made *only with your written permission.* Examples of requests requiring written authorization include release of PHI to:

- Another physician,
- Yourself or a family member,
- A life insurance company.

If you have provided us with your permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your written authorization.

♦ **Right to a Paper Copy of This Notice:** You may ask us to give you a copy of this notice at any time.

Vein and Vascular Centers provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ACKNOWLEDGEMENT OF RECEIPT OF Vein and Vascular Centers, SC PRIVACY NOTICE

I have the right to request a copy of Vein and Vascular Centers Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

A confidential message may be left on your voicemail and answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such messages may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff.

I request the following restriction(s) concerning the use of my personal protected health information and also include preferred phone number and email address:

____

Patient Name: _________________________________ DOB: ___________________

Patient Signature:______________________________

If not signed by patient, please indicate relationship to patient: ________________