UNIVERSITY of VIRGINIA HEALTH SYSTEM

UVA RADIOLOGY VEIN AND VASCULAR CARE REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

_____ _____

Date

UVA Radiology Vein and Vascular Care

Patient Screening Form

Please Answer the Following Questions As Completely As Possible

PATIENT NAME _____ DOB _____ DATE _____

Primary Care Physician: _____

REASON FOR VISIT: _____
_____
_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

Have you been treated or seen for this problem prior to today's visit? _____
If so when? _____ Where? _____

What makes the problem better? _____
What make the problem worse? _____

Past medical history: _____
_____
_____
_____
_____
_____

ALLERGIES: List allergies to foods or medicines and check reaction to each

☐ No Known Allergies

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Are you currently being treated for or have been treated for any of the following? Please check all that apply:

NEUROLOGICAL

- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Dementia
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____

CARDIOVASCULAR

- ☐ Heart attack
- ☐ Atrial fibrillation
- ☐ Cardiomyopathy
- ☐ Peripheral vascular disease
- ☐ Congestive heart failure (CHF)
- ☐ High blood pressure
- ☐ Pacemaker/AICD
- ☐ Other _____

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Lung cancer
- ☐ Sleep apnea
- ☐ Chronic lung disease
- ☐ Other _____

GASTROINTESTINAL

- ☐ Heartburn/reflux (GERD)
- ☐ Cirrhosis
- ☐ Hepatitis B or C
- ☐ Stomach or intestinal ulcers
- ☐ Cancer
  - ☐ Liver
  - ☐ Pancreas
  - ☐ Colon
  - ☐ Stomach
- ☐ Other _____

GENITOURINARY

- ☐ Kidney disease
  - ☐ Dialysis
- ☐ Prostate issues
- ☐ Cancer
  - ☐ Kidney
  - ☐ Bladder
  - ☐ Prostate
- ☐ Female issues
  - ☐ LMP _____
- ☐ Other _____

MUSCULOSKELTAL

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Other _____

ENDOCRINE

- ☐ Thyroid issues
- ☐ Diabetes Type _____
- ☐ Other _____

SKIN

- ☐ Ulcers/wounds
- ☐ Cancer

BLOOD DISORDERS

- ☐ Clotting disorders
- ☐ Anemia
- ☐ Sickle cell
- ☐ HIV

OTHER

- ☐ Depression/anxiety
- ☐ Substance abuse

SURGERIES

☐ Appendectomy
☐ Cholecystectomy (gallbladder removal)
☐ Cesarean section
☐ Joint surgery _____
☐ Spine surgery _____
☐ Breast surgery _____
☐ Prior vascular (Vein/artery) procedures _____
☐ Open heart surgery (Bypass or valve) _____
☐ Hysterectomy or female surgery _____
☐ Other _____

SOCIAL HISTORY

Smoking:

_____ Never

_____ Current
How many years? _____
How many packs per day _____

_____ Former
When did you quit? _____
How many packs per day? _____
For how many years? _____

Alcohol:

_____ Never

_____ Current
How many drinks per week? _____

_____ Former

Recreational Drugs:

_____ Never

_____ Current

_____ Former

CURRENT MEDICATIONS

☐ Not taking any current medications

Pharmacy: _____ Location: _____
Pharmacy phone number (if available): _____

*Please included daily prescribed medications and medications used only when needed

#	Medication Name	Dose	Frequency	Route
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				