WAKE RADIOLOGY

PATIENT VENOUS HISTORY

First Name _____ Last Name_____ Date_____ DOB _____ ☐ Male ☐ Female

VENOUS HISTORY

1. Are you seeking vein treatment for medical reasons, cosmetic reasons, or both? ☐ Medical ☐ Cosmetic ☐ Both medical and cosmetic
2. Do these symptoms interfere with your activities of daily living? ☐ Yes ☐ No
3. How long have you had veins that you are concerned about? _____
4. Are they getting worse? ☐ Yes ☐ No ☐ Not sure
5. Have you had any prior treatment for varicose/spider veins? ☐ Yes ☐ No
   If yes, approximate dates of treatment and physician who treated you (Dates/MD). _____ / _____
   Type of agent(s) used to treat, if known: _____
6. Do you have any history of poorly healing leg wounds or clots in your veins? ☐ Yes ☐ No
7. How many pregnancies have you had? ☐ None _____
   Did you varicose/spider veins increase after your pregnancies? ☐ Yes ☐ No
8. Do you wear support hose? ☐ Yes ☐ No ☐ Sometimes ☐ When traveling only
   If yes, are they prescription or over-the-counter? ☐ Prescription ☐ Over-the-counter
   If yes, how long have you been wearing them? _____
   Do or did they help you? ☐ Yes ☐ No
9. If presently employed, what type of job do you have? _____
10. Do you sit or stand for long periods of time each day? ☐ Sit ☐ Stand
    How many hours per day?____
11. Do you take any pain medications for your varicose/spider veins (aspirin/Tylenol)? ☐ Yes ☐ No
    Does it help? ☐ Yes ☐ No
12. Do you elevate your legs to relieve your symptoms? ☐ Yes ☐ No
    Does it help? ☐ Yes ☐ No

COMPREHENSIVE HISTORY CHECKLIST

CONDITION				OFFICE USE ONLY
Spider Veins	☐ Right Leg	☐ Left Leg	☐ Both	
Varicose Veins	☐ Right Leg	☐ Left Leg	☐ Both	
Tired Legs	☐ Right Leg	☐ Left Leg	☐ Both	
Pain	☐ Right Leg	☐ Left Leg	☐ Both	
Leg Swelling	☐ Right Leg	☐ Left Leg	☐ Both	
Aching	☐ Right Leg	☐ Left Leg	☐ Both	
Burning/Itching	☐ Right Leg	☐ Left Leg	☐ Both	

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PATIENT REGISTRATION FORM

Today's date_____ Referring Physician/Practice Name_____ | _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name	Date of Birth / /	Age	Sex ☐ Male ☐ Female

Street Address or PO Box	City	State	ZIP

Social Security No.	Home Phone	Work Phone	Cell Phone

Occupation	Employer	Employer Phone

PROGRESS NOTES

Date	
	Medications:
	Allergies:
	Surgeries:
	Hospitalizations (ex. pneumonia, blood clots, trauma):
	Illnesses (ex. high blood pressure, diabetes):

	OFFICE USE ONLY	Headache
		Blood Clots
		Stroke
		Migraine

WAKE RADIOLOGY CARY VEIN CENTER

Appointment Date	Arrival Time	Exam Time

Exam Ordered	Exam Location

IMPORTANT: If you have questions about your exam or if you cannot keep your appointment, please notify us 24-hours in advance by calling **WR Express Scheduling at 919-232-4700.**

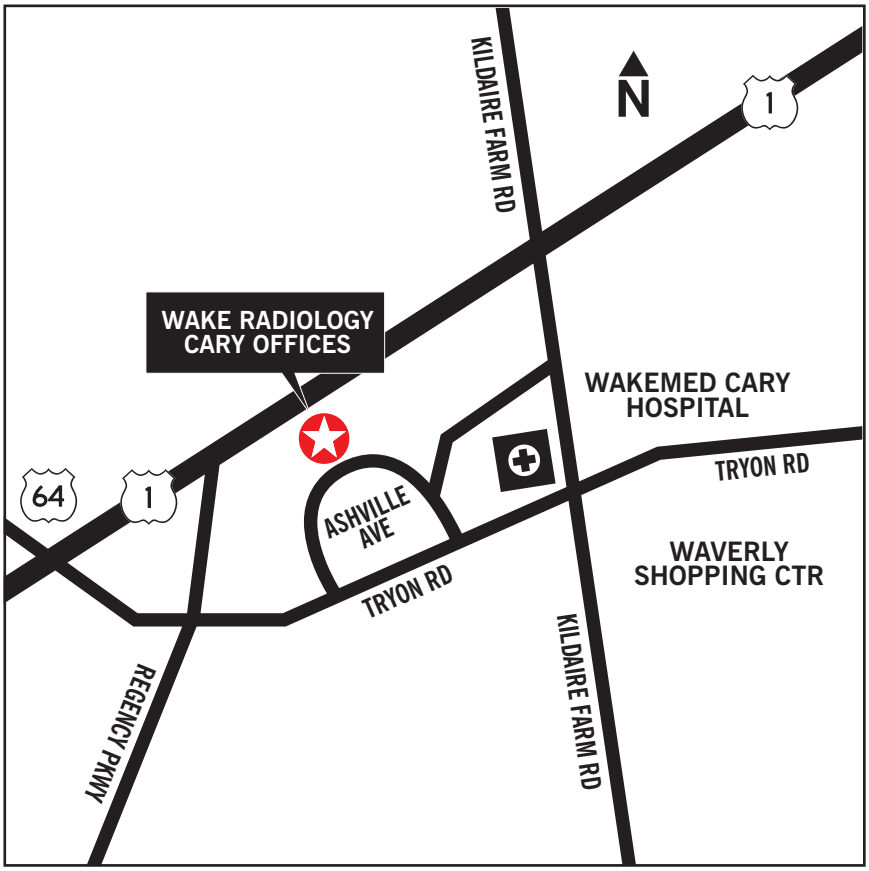
Please bring all insurance information to each visit.

Wake Radiology employees are unable to watch unattended children. Thank you for making arrangements for child care prior to coming to our office for your exam.

DRIVING DIRECTIONS: For step by step driving directions, view our Website **wakerad.com** and select the **Locations** tab, then **Offices,** then scroll down to view **Wake Radiology Cary.**

WAKE RADIOLOGY CARY VEIN CENTER

300 Ashville Avenue, Ste 160 | Cary, NC 27518
Office: 919-854-2180



DIRECTIONS

From the I-440 Beltline:

Take Exit 1 (US 1 South).

Take Exit 98-A (Tryon Road, East).

MERGE onto Tryon Road.

Between the second and third traffic lights, turn left onto Ashville Ave.

The fourth driveway on the right is our parking lot.

Lost or on the way? Call the office directly to inform the staff at 919-854-2180.

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