

**David D. Shin, MD, RVT, RPVI, FACS**  
**Texas Surgical Associates**  
**Houston Vein Specialists**

Please fill in the following information:

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

SS#: \_\_\_\_\_ Sex:  Male  Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Insurance Information: Please Give Receptionist Cards

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder Information: SS# \_\_\_\_\_ Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Why are you here today?:

\_\_\_\_\_

Past Medical History (Please check all that apply):

Anemia  Arthritis  Asthma  Bleeding Disorder  Blood Clots  Diabetes

Emphysema  Heart Disease  Hepatitis  High Blood Pressure

High Cholesterol  HIV  Inflammatory Bowel Disease  Kidney Disease

Migraines  Pneumonia  Pregnancy  Seizure Disorder  Stomach Ulcers

Stroke  Thyroid Disease  Tuberculosis  Cancer/Type: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

List Past Surgeries and Dates:

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Medications and Dosages:

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Allergies and Type of Reaction:

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Social History:

Do you:  Smoke/How much \_\_\_\_\_  Drink Alcohol/How Much \_\_\_\_\_  Use IV Drugs

Marital Status:  Single  Married  Divorced  Widowed

What is your occupation: \_\_\_\_\_

Family History:

Do any family members have:

Varicose Veins  Blood Clots  Heart Trouble  Stroke  High Blood Pressure

Diabetes  Bleeding Disorders  Cancer/Type \_\_\_\_\_

Please check all that apply (ROS):

**General:**  Appetite Change  Weight Change  Fever  Chills

**Skin:**  Color Change  Itching  Change in Moles  Rash

**Eyes, Ears, Nose, Throat:**  Visual Problems  Hearing Problems  Earache

Difficulty Swallowing  Hoarseness

**Cardiac:**  Chest Pain  Shortness of breath

**Vascular:**  Leg Pain  Foot Ulcers  Varicose Veins

**Respiratory:**  Allergies  Sinus Trouble  Cough  Wheezing  Bloody Cough

**Gastrointestinal:**  Heartburn  Nausea  Vomiting  Diarrhea  Constipation

Abdominal Pain  Stool Color Change  Blood in Stools

**Genitourinary:**  Painful Urination  Blood in Urine  Trouble Urinating

**Men:**  Breast Lump  Erection Difficulties  Testicle Pain/Lump  Penis Discharge

**Women:**  Breast Lump  Nipple Discharge  Vaginal Discharge  Menopause

Pregnancy/# of times \_\_\_\_\_  Last Menstrual Period \_\_\_\_\_

**Musculoskeletal:**  Back Pain  Painful Joints  Joint Swelling

**Neurologic:**  Weakness  Numbness  Headaches  Fainting

**Endocrine:**  Heat or Cold Intolerance  Excessive Thirst

**Hematologic:**  Bleed or Bruise Easily  Required Blood Transfusion

**Psychiatric:**  Fatigue  Difficulty Sleeping  Anxiety  Depression

**Other:** \_\_\_\_\_