HOUSTON VEIN SPECIALISTS
David D. Shin, MD, RVT, RPVI, FACS
6550 Fannin Street, Suite 2407
Houston, TX 77030
713-790-0000

Please fill in the following information:

Date:____________________

Last Name:______________________ First Name:_____________________ Middle Initial:_____

SS#:__________________________ Sex: ☐Male ☐Female

Age:_____ Birthdate:_________________

Home Address:____

City:_____________________ State:________________ Zip:______________

Cell Phone:________________________________

Home Phone:________________________ Work phone:_______________________________

Email Address: ____________________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Referring Doctor:___________________________

Insurance Information: Please Give Receptionist Cards

Primary Insurance:___________________________ Policy Holder:_________________________

Secondary Insurance:_________________________ Policy Holder:_________________________

Policy Holder Information (if not patient):

SS#______________________________ Birthdate:______________

Emergency Contact

Name:___________________ Relationship:______________ Phone Number:_______________

Pharmacy Information

Name of Pharmacy:____________________ Pharmacy Phone Number:_____________________

Why are you here today? (check all that apply):

☐Spider Veins ☐Varicose Veins ☐Leg Pain ☐Leg Swelling ☐Skin Discoloration ☐Leg Ulcer

Other:____

Past Medical History (Please check all that apply):
☐Arthritis ☐Asthma ☐Bleeding Disorder ☐Blood Clots ☐Diabetes
☐Coronary Heart Disease ☐Heart Arrhythmias ☐Valvular Heart Disease
☐High Blood Pressure ☐HIV ☐Kidney Disease ☐Migraines ☐Seizure Disorder
☐Peptic Ulcer Disease ☐Stroke ☐Hepatitis/Type______ ☐Cancer/Type:_______________

____

List Past Surgeries and Dates:
____
____
____

Medications and Dosages:
____
____
____
____
____

Allergies and Type of Reaction:
____

Social History:
Do you smoke? ☐Yes ☐No

What is your occupation: _________________________________

Family History (Mark if any family member has the following problems):
☐Varicose Veins ☐Blood Clots (location) _______________

Please check all symptoms that apply:
General: ☐Weight Gain ☐Weight Loss ☐Fever ☐Chills
Skin: ☐Color Change ☐Itching ☐Rash
Cardiac: ☐Chest Pain ☐Shortness of breath
Vascular: ☐Leg Pain ☐Leg Ulcers ☐Varicose Veins
Respiratory: ☐Allergies
Gastrointestinal: ☐Heartburn ☐Stomach Ulcers
Women: # of Pregnancies ______ # children__________
Last Menstrual Period _______________ ☐Menopause ☐Tubal Ligation
Musculoskeletal: ☐Back Pain ☐Painful Joints ☐Joint Swelling
Hematologic: ☐Bleed or Bruise Easily

Name: ___________________________ Date: _____________________