

**R.V. RAO, M.D., M.S. (Surg) F.A.C.S., F.I.C.S.**

Diplomate American Board of Surgery  
General Surgery and Vascular Surgery

**PATIENT REGISTRATION**

DATE

NAME	MARITAL STATUS S   M   W   D   SEP	DATE OF BIRTH	
STREET ADDRESS		CITY STATE, ZIP	
PHONE (HOME)	(WORK)	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION
S S #	DRIVER'S LICENCE #	REFERRED BY	

**INSURANCE & BILLING INFORMATION**

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE #

**PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I D #	GROUP #
		BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I D #	GROUP #
		BENEFIT CODE
MEDICARE #	MEDICAID I D #	
OTHER COVERAGE		

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. RAO, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. RAO, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**MEDICARE • MEDICAID**

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf

*A photocopy of these assignments shall be valid as the original.*

PATIENT (please print)

DATE

PARENT / GUARDIAN (please print)

SIGNATURE

# INFORMAT FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination  
It will help your physician to know not only about your health but also about your family and relatives

TODAY'S DATE

NAME ADDRESS

TELEPHONE NUMBER DATE OF BIRTH AGE PLACE OF BIRTH RACE OR NATIONALITY OF PARENTS

RELIGION EDUCATION (Highest level attained) OCCUPATION ▶ HOW LONG

PRESENT MARRIAGE (Year married) PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

<b>ALIVE ▶</b>	<b>FATHER</b>	Present health or cause of death	<b>MOTHER</b>	Present health or cause of death	<b>SPOUSE</b>	Present health or cause of death
<b>DECEASED ▶</b>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<b>BROTHERS ▶</b>	<b>NO ALIVE</b>	HEALTH		<b>NO DECEASED</b>	CAUSE OF DEATH	
<b>SISTERS ▶</b>	<b>NO ALIVE</b>	HEALTH		<b>NO DECEASED</b>	CAUSE OF DEATH	
<b>CHILDREN ▶</b>	<b>NO ALIVE</b>	AGES & HEALTH		<b>NO DECEASED</b>	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES  Diabetes  Cancer  Bleeding tendency  Kidney disease  
 Tuberculosis  Heart disease  Stroke  High blood pressure  Nervous illness  Allergy  Other

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD  Diabetes  Glaucoma  Heart trouble  Syphilis  Vein trouble  
 Cancer  Asthma  Jaundice  Gonorrhoea  Bleeding tendencies  Tuberculosis  Pneumonia  Kidney disease  
 Rheumatic fever  Nervous disorder  Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

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HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC ?  
 No  Yes ▶ LIST

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HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?  
 NO  Yes ▶ LIST.

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DO YOU USE TOBACCO NOW?	IN THE PAST?	TYPE AND DAILY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		
DO YOU USE ALCOHOLIC BEVERAGES?		WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			
DO YOU DRINK COFFEE?		WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED  
 Smallpox  Tetanus  Typhoid  Polio  Influenza  Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

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DENTAL (List any problems you have now)

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MEDICATIONS (Name or otherwise identify medicines now or recently used)

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ONSET DATE OF LAST MENSTRUAL PERIOD PERIODS ARE NUMBER OF PREGNANCIES NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ORAL CONTRACEPTIVES? HAVE YOU RECEIVED A BLOOD TRANSFUSION?

No  Yes  No  Yes  No  Yes ▶ DATE

DRESSED WEIGHT HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

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WHAT IS YOUR MAIN SYMPTOM?

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REVIEWED BY (Physician) DATE

CLINIC FOR VEINS  
**Vein Questionnaire**

Do you have or have you had:	Yes	No	Right	Left
1. Unsightly varices.	---	---	---	---
2. Aches and pains.	---	---	---	---
3. Heaviness and tired legs.	---	---	---	---
4. Ankle edema/swelling.	---	---	---	---
5. Itching.	---	---	---	---
6. Night cramps.	---	---	---	---
7. Bleeding from the veins.	---	---	---	---
8. Pigmentation.	---	---	---	---
9. Dermatitis(eczema )	---	---	---	---
10. Ulceration.	---	---	---	---

**Previous History:**

1. Superficial phlebitis.	---	---	---	---
2. Deep thrombo phlebitis.	---	---	---	---
3. Pulmonary Emboll (clot in the lung )	---	---	---	---

**Previous Treatment Modalltles:**

1. Compression stockings.	---	---	---	---
2. Ligation.	---	---	---	---
3. Stripping	---	---	---	---
4. Local excision.	---	---	---	---
5. Caval ligation.	---	---	---	---
6. Cautery(electric needle )	---	---	---	---
7. Sclerotherapy.	---	---	---	---

**Arterial Problems:**

1. Leg pain while walking in the:	---	---	---	---
a) Foot.	---	---	---	---
b) Calf.	---	---	---	---
c) Thigh.	---	---	---	---
d) Buttock.	---	---	---	---
2. Leg pains, resting:	---	---	---	---
a) Foot.	---	---	---	---
b) Calf.	---	---	---	---
3. Erection.	---	---	---	---
4. Dizzy spells.	---	---	---	---
5. Transient vision loss.	---	---	---	---
6. Transient weakness of a limb.	---	---	---	---
7. Previous bypass.	---	---	---	---

Other:

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**Medications Currently (please list):**

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	Yes	No
<b>Are currently on:</b>		
1. Oral contraceptives/ premarin	---	---
2. Aspirin	---	---
3. Steroids	---	---
4. Anticoagulant (coumadin)	---	---
5. Digoxin	---	---

**Allergies- Sensitivities:**

1. Do you have any history of skin reactions (rash, hives) or any other reactions or sicknesses following administration/ intake of drugs, If Yes, please list:	---	---
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**Are you allergic to:**

1. Iodine	---	---
2. Local Anesthetics (Xylocaine)	---	---
3. Tape	---	---

**Family History of Varicose or Spider Veins**

1. Has anyone in your family have or had the similar problem? Who? (please circle): Mother, Father, Sister, Brother, Uncle, Aunt, other: _____	---	---
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**Personal History of Varicose or Spider Veins:**

Number of Years \_\_\_\_\_

Onset:

1. Before Pregnancy
2. During/ after pregnancy
3. Related to O.C. / Premarin
4. After accident/ Trauma
5. Not related to the above

Are you required to be on your feet or sit for a long eriod of time?	---	---
Are you developing new veins?	---	---
Do you bruise easily?	---	---
Bleeding Disorders (excessive bleeding)?	---	---