The Art of Vein Care
VARICOSE VEINS
MD CARE

Y. H. SALEM M.D.

General and Vascular Surgery

OC Reflux
Huntington Beach, CA

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle:** _____

Marital Status: Single Married Widowed Divorced **Sex:** Male Female

Address:_____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home # : _____ **Cell # :** _____

Date of Birth : _____ **Social # :** _____

Employer: _____ **Work # :** _____

Occupation: _____ ****Email:** _____

**** PLEASE PROVIDE OUR OFFICE AN E-MAIL ADDRESS. WE WOULD LIKE TO COMMUNICATE WITH YOU REGARDING UP-COMING APPOINTMENTS, AUTHORIZATION INFORMATION SUCH AS DENIALS AND APPROVALS. THANK YOU.**

INSURANCE INFORMATION

Responsible / Insured : _____ **Date of birth:** _____

Social # : _____ **Employer:** _____

Relation to Patient: _____ **Insurance :** _____

ID # : _____ **Group # :** _____

EMERGENCY CONTACT(PERSON WHO DOES NOT LIVE WITH YOU)

Name: _____ **Relation to patient:** _____

Tel # : _____ **Cell or Work # :** _____

PHYSICIAN INFORMATION

Primary Care: _____ **Tel #** _____ **Fax #** _____

Referred By : _____ **Tel #** _____ **Fax #** _____

Consent for Use and Disclosure of Personal Information

This form authorizes our office to use and disclose your protected personal health information for healthcare operations, treatment and payment activities.

I _____, give written consent for my personal health information to be used for the purposes above mentioned.

And to protect my privacy, I wish to be contacted in the following manner only:
(check all that apply)

- Home telephone number
- Cell Phone number
- Work Telephone
- Written Communication/ E-Mail

I authorize Yasser Salem, MD Inc. to release any or all information pertaining to my healthcare information including treatments, test results to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Assignment to Pay Physician

I herby authorize direct payment of all medical benefits for services rendered to myself or my dependants to Yasser Salem, MD Inc. I agree to the responsibility of paying for all charges to my account not covered or paid for by my medical insurance, such as co pays, deductibles, and denied claims. Unless a prior written agreement is made to indicate otherwise.

Print Name: _____

Patient Signature: _____ Date: _____

HISTORY QUESTIONARE

Patient Name: _____ **DOB:** _____

Weight: _____ **Height:** _____ **Age:** _____

Medications

Name	Reason

Allergies to medications: _____

Previous Surgeries

Procedure/ Surgery	Date

Social Habits

Do you smoke? **NO** **YES** If yes, how many packs per day? ____
If you have quit, how long ago? ____

Do you use alcohol? **NO** **YES** If yes, how often do you drink? ____
If you have quit, how long ago?

****FEMALES ONLY** **# OF CHILDREN:** ____

HISTORY QUESTIONARE

Symptom Review

Eyes
- ☐ double vision

ENMT
- ☐ thyroid problems
- ☐ neck mass

Cardiovascular
- ☐ chest pain
- ☐ claudication
- ☐ edema

Respiratory
- ☐ cough
- ☐ dyspnea
- ☐ shortness of breath

Gastrointestinal
- ☐ abdominal pain
- ☐ melena
- ☐ hematochezia

Nausea
- ☐ vomiting
- ☐ weight loss

Genittourinary
- ☐ urinary problems
- ☐ blood in urine

Musculoskeletal
- ☐ muscle pain
- ☐ muscle weakness,ndules

Integumentary
- skin changes
- ☐ skin itching

Neurological
- ☐ syncope
- ☐ sensory defecit
- ☐ motor defecit

Psychiatric
- ☐ mood swings
- ☐ depression
- ☐ anxiety

Endocrine
- ☐ intolorance to cold
- ☐ intolorance to heat
- ☐ weight changes

Hematologic/lymphatic
- ☐ bleeding disorders
- ☐ swollen glands

Allergic
- ☐ seasonal allergies

Family History

	father	mother	brother	sister	grandparent/ other	
Colon or Rectal Cancer						
Breast Cancer						
Heart Disease						
Diabetes						
High Blood Pressure						
Liver Disease						
High Cholesterol						
Alcohol/drug abuse						
Depression/						
Varicose Veins						
Acid Reflux						

MOTHER: ALIVE DECEASED

FATHER: ALIVE DECEASED