

# NOVI VEIN

46325 W 12 Mile Road  
Suite 335  
Novi, Michigan 48377

Phone 248.344.9110  
Fax 248.344.9111

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First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of birth \_\_\_\_\_  Male  Female

Occupation \_\_\_\_\_  Full-time  Part-time  Retired

Contact Numbers Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Which number would you prefer we use? \_\_\_\_\_ E-mail (office use only) \_\_\_\_\_

Marital Status  Single  Married \*\*  Divorced  Widowed

\*\* If married:  
Spouse's Name \_\_\_\_\_  
Spouse's date of birth \_\_\_\_\_

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## PRIMARY INSURANCE

Subscriber  self  spouse

Blue Cross Blue Shield of Michigan  Medicare  Cofinity  
 Blue Cross Blue Shield of \_\_\_\_\_  Aetna  Other \_\_\_\_\_  
 Blue Care Network  Priority Health  
 Cigna  United Healthcare  I do not have insurance

## SECONDARY INSURANCE \_\_\_\_\_

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How did you hear about Novi Vein? \_\_\_\_\_

If you were referred by a Doctor, please list their name and number \_\_\_\_\_

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## IN CASE OF EMERGENCY

Contact Name \_\_\_\_\_

Contact Number \_\_\_\_\_

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

**\*\*NOTE: Please answer every question in the following pages. Thank you for your cooperation.**

**SECTION A:**

- 1. What brings you to Novi Vein today?
- 2. Have you ever sought treatment or consultation for this condition before? **Yes [ ] No [ ]**
- 3. Have you been diagnosed with Rosacea? **Yes [ ] No [ ]**

**SECTION B: MEDICAL HISTORY (Please check yes or no)**

<b>HEENT:</b>	<b>Yes</b>	<b>No</b>	<b>GENITOURINARY:</b>	<b>Yes</b>	<b>No</b>
Headaches	[ ]	[ ]	Blood in Urine	[ ]	[ ]
Thyroid	[ ]	[ ]	Painful Urination	[ ]	[ ]
Seizures	[ ]	[ ]	Kidney Stones	[ ]	[ ]
<b>CARDIAC:</b>	<b>Yes</b>	<b>No</b>	Urinary Tract Infection	[ ]	[ ]
Stroke	[ ]	[ ]	<b>SKIN:</b>	<b>Yes</b>	<b>No</b>
High Blood Pressure	[ ]	[ ]	Bruise Easily	[ ]	[ ]
Heart Disease	[ ]	[ ]	Skin Infection	[ ]	[ ]
Chest Pain	[ ]	[ ]	History of Skin Cancer	[ ]	[ ]
High Cholesterol	[ ]	[ ]	Eczema	[ ]	[ ]
Cardiac Pacemaker	[ ]	[ ]	Changes in Texture	[ ]	[ ]
Heart Murmur	[ ]	[ ]	<b>MUSCLES/EXTREMITIES:</b>	<b>Yes</b>	<b>No</b>
Mitral Valve Prolapse	[ ]	[ ]	Fractures	[ ]	[ ]
Rheumatic Fever	[ ]	[ ]	Arthritis	[ ]	[ ]
<b>LUNGS:</b>	<b>Yes</b>	<b>No</b>	Artificial Joints	[ ]	[ ]
Asthma or Lung Problems	[ ]	[ ]	Tobacco Use	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	Radiation Therapy	[ ]	[ ]
Pain with Respirations	[ ]	[ ]	Fibromyalgia	[ ]	[ ]
Hay Fever/Allergies	[ ]	[ ]	<b>VEINS:</b>	<b>Yes</b>	<b>No</b>
<b>GASTROINTESTINAL:</b>	<b>Yes</b>	<b>No</b>	Blood clots	[ ]	[ ]
Heartburn	[ ]	[ ]	Pulmonary Embolism	[ ]	[ ]
Recent Weight Loss	[ ]	[ ]	Clotting abnormalities	[ ]	[ ]
Stomach Ulcers	[ ]	[ ]	Superficial Thrombophlebitis	[ ]	[ ]
Liver disease or hepatitis	[ ]	[ ]	<b>OTHER:</b>	<b>Yes</b>	<b>No</b>
Bleeding	[ ]	[ ]	Diabetes	[ ]	[ ]
Constipation	[ ]	[ ]	Cancer	[ ]	[ ]
Diarrhea	[ ]	[ ]	Anemia	[ ]	[ ]
			HIV	[ ]	[ ]
			Liver Disease	[ ]	[ ]
			Sleep Apnea	[ ]	[ ]

Please list any other medical problems not listed. \_\_\_\_\_

4. Do you have a permanent pacemaker or other cardiac device? Yes [ ] No [ ]

5. Are you allergic to any medications? Yes [ ] No [ ]  
If yes, please list \_\_\_\_\_

6. Are you allergic to Latex? Yes [ ] No [ ]

7. Do you have a nickel allergy (please notify nurse)? Yes [ ] No [ ]

8. Please list below any surgeries you have had Please list all medications you are taking (incl. non-prescription, aspirin, birth control pills, vitamins)

	Surgeries	Dates		Name	Dosage
1	_____	_____	1	_____	_____
2	_____	_____	2	_____	_____
3	_____	_____	3	_____	_____
4	_____	_____	4	_____	_____
5	_____	_____	5	_____	_____
6	_____	_____	6	_____	_____
7	_____	_____	7	_____	_____

9. FAMILY HISTORY

	Yes	No	Relationship
Cancer	[ ]	[ ]	_____
Stroke	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Varicose Veins	[ ]	[ ]	_____
Cardiac Disease	[ ]	[ ]	_____

10. SOCIAL HISTORY

ALCOHOL Yes [ ] No [ ]  
If yes, how much and how often? \_\_\_\_\_

TOBACCO Yes [ ] No [ ]  
If yes, how much and how often? \_\_\_\_\_

11. Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Location: \_\_\_\_\_

I certify the information on this form is true and complete to the best of my knowledge and belief.

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