WESTERN RESERVE VASCULAR INSTITUTE, LLC
Joseph G. Protain, D.O.
813 Kentwood Drive, Boardman, OH 44512
Ph: (330) 953-3515Fax: (330) 953-0313

***NEEDED FOR EMR: YOU CAN DECLINE TO FILL OUT**
Race:_____
Ethnicity:Hispanic/Non-Hispanic/Other/Decline
Student: Yes ____ No ____

ALL MUST BE FILLED OUT PLEASE:

Name _____DOB_____Date _____Age _____ Sex_____Ht____ Wt___
Address _____Phone_____Cell_____
City _____State_____Zip_____ ***Email:**_____
SS#_____
Primary Ins:_____Policy:_____Group:_____Spouse Name_____DOB_____
Secondary or Spouse Ins:_____ Policy:_____ Group:_____ Spouse Name_____DOB_____
Family Physician: _____**Who sent you to our office**? _____
Reason for Appointment: _____
Previous Operations: (type, date, doctor)_____ _____
_____ _____

****Medication Allergies:** (Please list) _____

Do you have or have you had any of the following conditions? (Please circle)

Adverse Reaction to		Asthma	Yes No	Irregular heart beat	Yes No
Anesthesia	Yes No	Blood thinners	Yes No	Kidney problems	Yes No
AIDS (HIV)	Yes No	Cancer	Yes No	Pacemaker or Defibrillator	Yes No
Anemia	Yes No	Congestive Heart Failure	Yes No	Phlebitis/Blood clot	Yes No
Arthritis (type)	Yes No	Diabetes (type)	Yes No	Pulmonary Embolism	Yes No
Artificial Heart Valve	Yes No	Heart Attack	Yes No	Respiratory problems (what kind)	Yes No
Artificial Joints	Yes No	Hepatitis A B C	Yes No	Stroke	Yes No
High Blood Pressure	Yes No				

Please list any other **serious illness** or **injury**: _____
Smoking status(**Circle one**): Currently smoke, past smoker or never Amount _____Quit: _____
Do you drink Alcohol? **Yes No** Amount, **What kind**?_____
Do you use street drugs? **Yes No** Type? _____

Please list current medications and *WHAT IS THE DOSE YOU ARE TAKING*: (or bring list)

_____ _____ _____
_____ _____ _____

Do you have a **family history** of any of the following conditions? **If yes, please list *FAMILY MEMBER RELATIONSHIP*. (living or deceased)**
Cancer and type where_____ Stroke _____ Diabetes type?_____
Hypertension _____Heart disease _____Bleeding problems_____

ROS Do you have any of the following symptoms?	yes	no		yes	no
			MS Joint Pain (**where**)		
Weight change: Loss _____lbs. Gain _____lbs			Back Pain (**where**)		
Eyes Blurred or Double Vision			Psych Depression		
Loss of Vision			MRDD		
ENT Sore throat			Psych Other: List		
CV Palpitations					
Chest pain					
Resp Shortness of breath			Leg Ulcers (**where**)		
Fatigue			Leg Pain (**where**)		
Persistent cough			Compression Stocking (how have you worn)		
GI Diarrhea			Leg Elevation		
Nausea/Vomiting			Exercise (any? what kind)		
Neuro Paralysis/Numbness (**where**)					
Headaches (**type**)					

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VARICOSE VEIN QUESTIONNAIRE

NAME:_____ **DATE:**_____

VEIN HISTORY

What is the reason why you are seeking treatment? Cosmetic Medical

****How long have you had the problem ?** _____ **Right___ Left___ Both___**

Have you seen any other doctors for treatment of your veins? Yes No

If yes, please explain: _____

****Do you or have you ever worn compression stockings? Yes No**
****(this is very important insurance requires you to wear at least 3 months so please try to remember all dates that you have worn any types of compression stockings!)**

If yes, please list what type you use (d) _____Do/did they help? Yes No

****How long were the stockings worn? _____**

Have you ever had a blood clot in your leg? Yes No

If yes, please detail when and in which leg: _____

Do you experience any of the following symptoms in your legs?

Aching/Pain	Yes	No	Swollen Ankles	Yes	No
Heaviness	Yes	No	Leg Cramps	Yes	No
Tiredness/Fatigue	Yes	No	Throbbing	Yes	No
Itching/Burning	Yes	No	Restless Legs	Yes	No

Any other leg symptoms? _____

****Do you have problems walking? Yes No** ****Do you have problems with exercise? Yes No**

If yes, please explain: _____

Are your symptoms worse at the end of the day? Yes No

Are the problems you are having in your legs interfering with your lifestyle? Yes No

HOW:_____

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ☐ Protected health information may be disclosed or used for treatment, payment or health care operations
- ☐ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- ☐ The Practice reserves the right to change the Notice of Privacy Practices
- ☐ The patient has the right to restrict the uses of their information but the practice doesn't not have to agree to those restrictions
- ☐ The patient may revoke this Consent in writing at anytime and all future disclosures will cease
- ☐ The Practice may condition receipt of treatment upon the execution of this consent

This consent is signed by: _____
Printed name—Patient or Representative (if pt a minor)

_____ Date: _____
Signature

Witness: _____ Date: _____
Signature

WESTERN RESERVE VASCULAR INSTITUTE, LLC

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

Patient Name_____

Date of Birth_____

At times patients may wish to have information regarding their medical conditions(s), lab reports, diagnostic test results, medications, appointment dates/times, etc., discussed verbally with other individuals such as a spouse, family member, friend or caregiver in the office or by telephone. Please indicate below any person whom you authorize us to verbally release information to regarding your care at Western Reserve Vascular Institute, LLC.

We will release information to the individual name(s) listed below that you have authorized for the duration of your care at Western Reserve Vascular Institute, LLC unless you contact us with changes.

I do not wish to have any medical information discussed with anyone but myself.

Initial here_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Effective April, 2003 federal law requires us to offer you a copy of our privacy notice and to obtain your acknowledgement that we offered you a copy. Please tell us if you would like a copy of our privacy notice.

I have been offered a copy of Western Reserve Vascular Institute, LLC's Privacy Notice and have completed the Authorization for Verbal Release as indicated.

Patient Signature_____ Date_____

********SEE OTHER SIDE PLEASE********