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East Texas Surgical Associates, PA
Llewellyn Lee, MD
Charles J. Gutierrez, MD, FACS

Patient Demographics

PATIENT INFORMATION:

Patient Name: _____ **SS#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: ___/___/_____ **Sex:** □Male □Female **Marital Status:** □Married □Single □Divorced □Widowed

Race:□American Indian or Alaskan Native, □Asian, □Black or African American, □Caucasian, □Chinese, □Filipino, □Hispanic, □Japanese, □Multi-racial, □Native, □Hawaiian, □Pacific Islander, □Other, □Undetermined, □Pt Declines

Language: □English, □French, □German, □Japanese, □Korean, □Latin, □Spanish, □Vietnamese, □Patient Declines

Ethnicity: □Hispanic or Latino, □Not Hispanic or Latino, □Patient Declines to State

Employer (if applicable):_____ **Occupation:** _____

Employment Status: □Full-time, □Part-time, □Housewife, □Unemployed, □Retired

Student Status: □Full-time, □Part-time

Pharmacy Name / Location: _____ **Patient Email Address:** _____

RESPONSIBLE PARTY INFORMATION: (complete only if different from patient)

Guarantor: _____ **Date of Birth:** ____/____/_____ **SS#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact: (or someone not in your household)

Name: _____ **Relation:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____**Group:** _____

Name of Insured: _____ **Date of Birth of Insured:** ____/____/_____

Secondary Insurance Name: _____

Policy #: _____**Group:** _____

Please Give Insurance Card(s) and Driver License to Front Des

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Health Assessment and History

Name: _____ Date: ____/____/_____
DOB: _____/_____/_____ Age: _____ Sex: _____ Height_____ Weight_____

CHIEF COMPLAINT:

_____

_____

Primary Care Physician: _____ Phone: _____
Home Health Agency: _____ Phone: _____
Pharmacy: _____ Phone: _____

CURRENT MEDICAL CONDITIONS: (example: High blood pressure, Diabetes)

Illness / Condition	Date	Illness / Condition	Date

SURGICAL HISTORY: (example: Hysterectomy, Appendectomy, Stent, Angiogram?)

Surgery	Date	Surgery	Date

HOSPITALIZATIONS: (Have you ever had a serious illness requiring a hospital stay other than surgery?)

Reason	Year	Hospital	Reason	Year	Hospital

Current Medications: (Please list prescriptions, over the counter, vitamins, herbs, etc)

Medication	Dose	How often	Medication	Dose	How often

Allergies: Are you allergic to any medications, food, environmental, IODINE, SHELLFISH, LATEX or other substances? Please specify allergy and reaction

□ No Known Allergies

Allergy	Reaction	Allergy	Reaction

Have you, or a blood relative, had a reaction to anesthetic? □Yes □No
If yes, please explain: _____

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Social History:

Occupation: _____ □ Full-time, □ Part-time, □ Retired, □ Homemaker, □ Unemployed, □ Disabled

Alcohol Use Screening:

□ No	□ Yes
	How often did you have a drink containing alcohol in the past year? □ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week
	How many drinks did you have on a typical day when you were drinking in the past year? □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more
	How often did you have 6 or more drinks on one occasion in the past year? □ Never □ Less than monthly □Monthly □ Weekly □ Daily or almost daily

Tobacco Use Screening:

□Nonsmoker	□ Former Smoker	□ Current Smoker
	How long has been since you last smoked? □ 1-3 months □ 3-6 months □ 6-12 months □ 1-5 years □ 5-10 years □ > 10 years	How often do you smoke cigarettes? □ everyday □ some days
		How many cigarettes a day do you smoke? □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more
		soon after you wake up do you smoke your first cigarette? □ within 5 minutes □ 6-30 minutes □ 31-60 minutes □ after 60 minutes
		Are you interested in quitting? □ Ready to quit □ Thinking about quitting □ Not ready to quit

Family History

□ Diabetes	□ Aneurysms	□ Varicose veins
□ Hypertension	□ Bleeding problems	□ Leg swelling
□ Heart Attack	□ DVT (Blood Clots)	□ Cancer
□ Stroke / TIA	□ Lupus	□ Other: _____

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Hepatic/Renal	**Yes**	**No**
Yellow Jaundice		
Hepatitis		
Cirrhosis		
Kidney Problems		
Blood in Urine		
Urinary Frequency		
Difficulty Urinating		
Mental	**Yes**	**No**
Anxiety		
Depression		
Agitation		
Excitability		
Forgetfulness		
Confusion		
Infectious Disease	**Yes**	**No**
HIV/AIDS		
Speech/Hearing	**Yes**	**No**
Language Problem		
Voice Problem		
Ringing in Ears		
Frequent Ear Inf.		
Hard of Hearing		
Deaf		
Dizziness		
Vision	**Yes**	**No**
Blind		
Cataracts		
Glaucoma		
Double Vision		
Blurring		
Pain (Eye)		
Low Vision		
Endocrine	**Yes**	**No**
Insulin Dependent Diabetes Mellitus		
Non-Insulin Dependent Diabetes		
Thyroid Disease		
Adrenal Disease		

Respiratory	**Yes**	**No**
Asthma		
Wheezing		
Shortness of Breath		
TB – History		
Emphysema		
Collapsed Lung		
Cardiovascular	**Yes**	**No**
Chest Pain		
Shortness of Breath		
Pacemaker		
Congestive Heart Failure		
Angina		
Heart Attack		
Bleeding Disorders		
Blood Clots (DVT/PE)		
Phlebitis		
Peripheral Vascular Disease		
Blood Transfusions		
Gastrointestinal	**Yes**	**No**
Abdominal Pain		
Diverticular Disease		
Blood in Stools		
Frequent Diarrhea		
Frequent Constipation		
Heartburn / Indigestion		
Nausea / Vomiting		
Special Diet		
Recent Weight Loss Amount Of Loss?		
Musculoskeletal	**Yes**	**No**
Arthritis		
Muscle Disease		
Physical limitation Cane/Walker Wheelchair/ Prosthesis Amputations/ Shoe Inserts		
Skin	**Yes**	**No**
Change in skin color		
Wounds		
Bruises		
Lesions		
Rash		

Neurological	**Yes**	**No**
Numbness / Tingling		
Paralysis		
Weakness		
Loss of Memory		
Seizures		
CVA / Stroke		
Headaches		
Pain	**Yes**	**No**
Having Pain?		
What Relieves It?		

Please explain any "Yes" answers from the above questions:

Occupation:

Last Flu Shot:

Last Pneumonia Vaccination:

Would you like for us to send your reports to your specialists?

Please List your Specialists:

Cardiologist(heart):
Neurologist(nerve):
Hematologist(blood):
Rheumatologist(arthritis):
Podiatrist(foot):
Dermatologist(skin):
Endocrinologist(hormone):
Pulmonologist(lung):
Pain Specialist:
Wound Care:

Patient:_____

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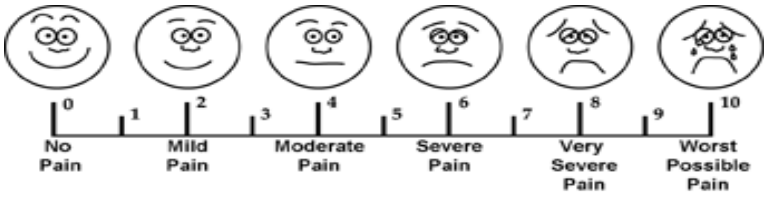
Venous Health History

Patient Name: _____ DOB: ____/____/_____

Do you experience any of the following in your legs?

	Left	Right	Comments (optional)
Aching / Pain	☐	☐	
Heaviness	☐	☐	
Tiredness / Fatigue	☐	☐	
Itching / Burning	☐	☐	
Swollen Ankles	☐	☐	
Leg Cramps	☐	☐	
Restless Legs	☐	☐	
Throbbing	☐	☐	
Other	☐	☐	
Activities Affected by Legs: Walking, Shopping, Exercising, Cleaning, Cooking, Showering, Job Functions			

What is the pain level in your legs? (select one)



Have you ever had the following?

	No	Left	Right	Date	Comments (optional)
Vein Stripping or Ablation	☐	☐	☐		
Vein Injections (Cosmetic)	☐	☐	☐		
Leg Ulcerations	☐	☐	☐		
Blood Clots (DVT / PE)	☐	☐	☐		
Phlebitis	☐	☐	☐		

Do you have a family history of varicose veins?	☐Yes	☐No	Who? _____
Have your symptoms worsened in recent months?	☐Yes	☐No	
Do you take any medication for pain in your legs?	☐Yes	☐No	What?_____ For how long?_____
Do you elevate your legs for discomfort?	☐Yes	☐No	How long? _____
Do you exercise?	☐Yes	☐No	How often? _____Type? _____
Do you wear / have you worn compression stockings?	☐Yes	☐No	Rx or OTC? _____How Long?_____
Do you have difficulty walking?	☐Yes	☐No	
Does your occupation require prolonged standing?	☐Yes	☐No	
Does your occupation require prolonged sitting?	☐Yes	☐No	

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Arterial Health History

Patient Name: _____ DOB: ____/____/_____

How long can you walk before developing leg pain?
□ 1 city block □ 2 city blocks □ 3 city blocks □ indefinitely □ Other:

Where does the pain occur? □ Foot, □ Leg Below Knee, □ Thigh, □ Other:

What relieves the pain? □ Resting leg in down position □ Resting leg in elevated position
□ Exercise: □ Medication: □ Other:

What makes the pain worse?

Have you ever had wounds on your: □ Foot □ Toe □ Leg □ Other: How long?
Did the wounds heal and return? □ Yes □ No

Do you have any prosthetics or implants? □ Yes, specify: □ No

Do you have a pacemaker? □Yes □No

Have you ever had the following tests?
Stress Test on the heart? □Yes □No When / Where? _____
MRI or CT scan? □Yes □No When / Where? _____
Angiogram of blood vessels? □Yes □No When / Where? _____
Lung function test / pulmonary function test? □Yes □No When / Where? _____
Heart catheterization / angiogram? □Yes □No When / Where? _____

Uterine Health History

Menstrual History

Length (Days #): _____ Heavy (Days #): _____ □ Pads □ Tampons □ Both

Frequency of change: _____ LMP: _____ 1st Menses (Age): _____

Pregnancies: _____ Live Births: _____ Miscarriages: _____ Elective Abortions: _____

□ Anemia □ Transfusions □ Blood Clots □ Frequency Constipation

□ Urinary Frequency □ Pelvic Pressure □ Pelvic Pain □ Other _____

□ Birth Control Pills: ____/____/____ □ Lupron / Depo-Provera: ____/____/____

Ob/Gyn: _____ Last Pap Smear: _____ Comments: _____

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Patient Name: _____ **DOB:** ____/____/_____

Special Needs: ☐ Cultural ☐ Communication ☐ Literate ☐ Developmental ☐ Religious ☐ Financial ☐ Foreign Language

Learning Style: ☐ Verbal ☐ Written ☐ Demonstration

PRESENT LIVING ARRANGEMENTS

☐ Home Alone
☐ Home with Family / Caregiver (who)_____ ☐Part-Time ☐Full-Time
☐ Nursing Home (name) _____ Group Home (name) _____
☐ Other, Explain: _____ Are pleased with the care you are receiving: ☐Y ☐N

PERSONAL CARE NEEDS (Based on Health Status)

Do you currently need or will you need, help with the following (check all that apply):
☐ Standing ☐ Walking ☐ Toileting ☐ Eating ☐ Wound Care ☐ Cooking
☐ Dressing ☐ Bathing ☐ Preparing Medications ☐ Transportation for health care needs
Explain: _____

DO YOU USE ANY OF THE FOLLOWING? (Check all that apply)

☐ Dentures Uppers (☐Full / ☐Partial)
☐ Glasses / Contacts
☐ Loose, chipped or cracked teeth
☐ Capped teeth or bridge work
☐ Hospital Bed
☐ Respiratory treatments / Inhalers
☐ Bi-Pap / C-Pap
☐ Dentures Lowers (☐Full / ☐Partial)
☐ Braces or retainers
☐ Hearing Aids (☐R ☐L ☐Both)
☐ Prosthesis / Implant
☐ IV Therapy
☐ Oxygen ___L/minute
☐ Other: _____

Advanced Directives – Please Bring with you	Yes	No	Explanation
Durable Power of Attorney	☐	☐	
Health Care Representative	☐	☐	
Do Not Resuscitate Document	☐	☐	
Living Will	☐	☐	
Life-Prolonging Procedures	☐	☐	
Do you have any of the above documentation?	☐	☐	
Where is the copy of the document	☐	☐	

Questionnaire completed by **Relationship** **Date**

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- CIVIQ – 14 –

SELF – QUESTIONNAIRE PATIENTS

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday life of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent. **For each symptom, sensation or type of discomfort listed, we would like you to answer in the following way:**

Please consider whether you have experienced what is described in each sentence, and if the answer is 'yes', how **intense** it was. There are five response options. Please circle the one which best describes your situation.

Circle 1 if the symptom, sensation of discomfort described does not apply to you

Circle 2,3,4 or 5 if you have felt it to a greater or lesser extent

1) During the past four weeks, have you had any pain in your ankles or legs, and how severe has this pain been?

Circle the number that applies to you.

No Pain	Slight Pain	Moderate Pain	Considerable Pain	Severe Pain
1	2	3	4	5

2) During the past four weeks, how much trouble have you had at **work** or with your **usual daily activities because of your leg problems?**

Circle the number that applies to you

No Pain	Slight Pain	Moderate Pain	Considerable Pain	Severe Pain
1	2	3	4	5

3) During the past four weeks, have you **slept poorly** because of your leg problems, and how often? *Circle the number that applies to you*.

No Pain	Slight Pain	Moderate Pain	Considerable Pain	Severe Pain
1	2	3	4	5

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	During the past four weeks, how much **trouble** have you had **carrying out the actions and activities** listed below **because of your leg problems?** *For each statement in the table below, indicate how much trouble you have had by circling the number that applies to you.*				
	No trouble	Slight trouble	Moderate trouble	Considerable trouble	Could not do it
4) Climbing several flights of stairs	1	2	3	4	5
5) Crouching / Kneeling down	1	2	3	4	5
6) Walking at a brisk pace	1	2	3	4	5
7) Going out for the evening, going to a wedding, a party, a cocktail party…	1	2	3	4	5
8) Playing a sport, exerting yourself	1	2	3	4	5

	Leg problems can also affect your spirits. How closely do the following statements correspond to how you have felt during the past four weeks? *For each statement in the table below, circle the number that applies to you*				
	No trouble	Slight trouble	Moderate trouble	Considerable trouble	Could not do it
9) I felt nervous/tense	1	2	3	4	5
10) I felt I was a burden	1	2	3	4	5
11) I felt embarrassed about showing my legs	1	2	3	4	5
12) I got irritated easily	1	2	3	4	5
13) I felt as if I was handicapped	1	2	3	4	5
14) I did not feel like going out	1	2	3	4	5