VIRGINIA RADIOLOGY ASSOCIATES, P.C.
Virginia Vascular Center
8401 Dorsey Circle, Suite 101
Manassas, VA 20110
Phone: 703-396-7669
FAX: 703-396-7987

Patient Name_____ Social Security No. _____-_____-_____

Date of Birth_____ Age_____ Sex _____ Home Phone No._____

Patient Address – Street_____City_____State_____Zip_____

Employer Name_____ Work Phone No. _____

Employer Address – Street _____City_____State_____Zip_____

Emergency Contact_____ Telephone No. _____

Next of Kin _____ Telephone No. _____

INSURANCE INFORMATION ----------

Primary Insurance Carrier	Secondary Insurance Carrier
_____	_____
Address_____	Address _____
_____	_____
Group No._____	Group No._____
Policy No. _____	Policy No. _____
Subscriber Name/DOB_____	Subscriber Name/DOB_____
Patient's Relationship to Insured _____	Patient's Relationship to Insured _____

***********PLEASE GIVE YOUR INSURANCE CARDS TO STAFF FOR COPYING.***********

PHYSICIAN INFORMATION ----------

Referring Physician _____ Telephone No. _____

Primary Care Physician (PCP) _____ Telephone No. _____

Surgeon _____ Telephone No. _____

Other Physicians _____ Telephone No. _____

TREATMENT AUTHORIZATION----------

I HEREBY AUTHORIZE THE PHYSICIANS OF VIRGINIA RADIOLOGY ASSOCIATES, P.C. TO UNDERTAKE EVALUATION AND TREATMENTS OF THE VARIOUS CONDITIONS FOR WHICH I PRESENT MYSELF.

Patient Signature_____ Date_____

PAYMENT AUTHORIZATION----------

I hereby authorize the physicians of Virginia Radiology Associates, P.C. to furnish medical information concerning my visits to my insurance company. I direct the insurer to pay, directly to the physician, all benefits due as a result of these claims. I am aware that I am personally responsible for all charges.

Patient Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES----------

I hereby acknowledge receipt of the Notice of Privacy Practices for Virginia Radiology Associates, P.C.

Patient Signature _____ Date _____

HOW DID YOU HEAR ABOUT US? A friend Newspaper Radio My doctor_____

VIRGINIA RADIOLOGY ASSOCIATES, P.C.
Virginia Vascular Center
8401 Dorsey Circle, Suite 101
Manassas, VA 20110
Phone: 703-396-7669
FAX: 703-396-7987

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

REASON FOR VISIT: _____
How long have you had this problem? _____
Does anything make the problem worse? _____
Does anything make the problem better? _____
Do you remember any incident which started the problem? _____
Weight: _____

SOCIAL HISTORY:
SMOKING □ Yes □ No How many packs per day?_____ How many years?_____
ALCOHOL □ Yes □ No How many drinks per day?_____ How many years?_____
DRUGS_____ Types_____ How many years?_____
MARITAL STATUS: □ Single □ Married □ Divorced □ Separated

FAMILY HISTORY:
MOTHER – □ Alive (any illnesses?_____)
□ Deceased (cause _____)
FATHER – □ Alive (any illnesses?_____)
□ Deceased (cause _____)
MATERNAL GRANDMOTHER □ Alive (any Illnesses?_____)
□ Deceased (cause _____)
MATERNAL GRANDFATHER □ Alive (any Illnesses?_____)
□ Deceased (cause _____)
PATERNAL GRANDMOTHER □ Alive (any Illnesses?_____)
□ Deceased (cause _____)
PATERNAL GRANDFATHER □ Alive (any Illnesses?_____)
□ Deceased (cause _____)

PAST MEDICAL HISTORY (Any Previous Illnesses?):_____
_____
PAST SURGICAL HISTORY (Any Previous Surgeries?)_____
_____
ALLERGIES: (Medications, Foods, Pollen)_____
What kind of reaction did you have? (rash, hives, difficulty breathing)
_____
MEDICATIONS: (Include Dosage and Frequency, Prescription and Nonprescription)
_____ _____
_____ _____
_____ _____

To Be Completed By Medical Staff:
HEENT _____ GI _____
CVS _____ GU _____
RESP _____ Bleeding Disorders _____

VIRGINIA VASCULAR CENTER

HEALTH HISTORY

Name: _____ Date: _____

Directions: Please answer the following questions, trying not to leave any blank spaces.

Past Medical History

1.	Are you presently under the care of a physician? If yes, for what reason? _____		Yes	No
2.	Do you have:	Heart Disease	Yes	No
		Lung Disease	Yes	No
		High Blood Pressure	Yes	No
		Hepatitis	Yes	No
		HIV/AIDS	Yes	No
		Arthritis	Yes	No
		Leg Ulcers	Yes	No
3.	Have you ever had a blood clot (deep vein thrombosis)? If yes, which leg and when?_____		Yes	No
4.	Have you ever had phlebitis (inflammation of a vein)? If yes, which leg and when?_____		Yes	No

Child Bearing History

5.	Do you think you are presently pregnant?	Yes	No
6.	How many times have you been pregnant? _____		
7.	Do you intend to have any more children?	Yes	No
8.	Are you presently breastfeeding?	Yes	No

Family History

Please circle the appropriate answer.

9. Does anyone in your family have varicose veins, spider veins, leg ulcers or swollen legs?

Father	Yes	No
Mother	Yes	No
Brother(s)	Yes	No
Sister(s)	Yes	No
Other _____	Yes	No

10. Do you experience any of the following?

Aching/pain in your legs?	Yes	No
Heaviness	Yes	No
Tiredness/fatigue	Yes	No
Itching/burning	Yes	No
Swollen ankles	Yes	No
Leg cramps	Yes	No
Restless legs	Yes	No
Throbbing	Yes	No
Other _____		

11. Have your veins gotten worse in recent months? Yes No

12. Do you have any problem walking? Yes No
If yes, how does it affect you? _____

13. Do you stand much at work? Yes No
at home? Yes No

14. How does this standing affect your legs? _____

15. Do you elevate your legs to relieve discomfort? Yes No

16. Do you wear support hose prescribed by a doctor? Yes No
If yes, how long have you worn them?_____
If yes, do they provide relief?_____

17. Do you wear light support hose (e.g. Sheer Energy)? Yes No
If yes, do they provide relief? Yes No

18. Have you ever had your veins evaluated before? Yes No
If yes, when and where? _____

19. Have you ever had any test(s) done on your veins? Yes No

20. Have you ever had vein-stripping surgery? Yes No
If yes, which leg and when? _____

21. Have you ever had vein injections? Yes No
If yes, when, where and which leg?_____

Patient's Signature_____ Date_____

Provider's Signature_____ Date_____