



Nicholas H. Hyde, M.D.

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PATIENT INFORMATION

Name _____ Date ____/____/____

Address/Apt _____ City/State/Zip _____

Home Phone _____ Work _____ Cell _____

Date of Birth ____/____/____ Age _____ Height ____ Weight ____ email _____

Referred by _____ History of Hepatitis or H IV _____

Please list any previous surgery _____

Please list any medical conditions, past or current _____

Current Medicines _____ Allergies _____ Pregnant now: Y N

Please check any of these leg vein symptoms that apply:

Pain ___ throbbing ___ aching ___ burning ___ itching ___ heaviness ___ fatigue ___

Reason for visit please check all that apply:

spider veins ___ varicose veins ___ blue-green reticular veins ___ (Botox) ___

Vein History : Either parent had spider or varicose veins? Y N

Do you have lupus or any clotting disorder? Y N

Do you wear graduated compression stockings regularly? Y N

Do you exercise regularly? Y N

Have you had previous vein treatment? If yes, please give dates and area of body:

Surface laser _____ Sclerotherapy _____ Surgical stripping or ligation _____

Payment for all services, including today's consultation or treatment, is due at the time of service unless other arrangements have been made. I hereby authorize photographs to be taken as part of my care, and to be used for educational purpose as Doctor Hyde sees fit as long as my identity is not divulged. Your signature implies everything in this form has been understood and answered honestly. Unfortunately Elite Vein Specialists must charge a \$100.00 fee for any treatment appointments cancelled without 24 hour notification. Thanks very much for your understanding with this issue.

Thank you for completing this questionnaire. Dr. Hyde and his staff will do their utmost to provide you with excellent care.