SOUTH SHORE VEIN
AND IMAGE-GUIDED MEDICINE

David T. Jacobs, MD DABR

Patient Medical History

Patient Name: ____________________________________ Occupation: ____________________

Address: ____

Email address: ________________________________ Cell:____________________

Date of Birth: __________________ Height:___________ Weight: ______________

How did you hear about us? ____

Primary Care Physician: ____

How long have you had this problem (please estimate)?__________________________________

Have you ever had treatment for your veins in the past? ◯ Yes ◯ No

if Yes, please explain: ____

____

Please check <u>YES</u> or <u>NO</u>: I have even been diagnosed with or treated for the following:

YES	NO		YES	NO		YES	NO	
◯	◯	Deep Vein Thrombosis	◯	◯	Pulmonary Embolus	◯	◯	Phlebitis/Blood Clots
◯	◯	High Blood Pressure	◯	◯	Heart Disease	◯	◯	Hepatitis
◯	◯	Diabetes	◯	◯	Asthma	◯	◯	Lung Disease/COPD
◯	◯	Arthritis	◯	◯	HIV/AIDS	◯	◯	Bleeding disorder
◯	◯	Peripheral vascular disease	◯	◯	Heart valve disease	◯	◯	Stroke

◯ Other ____

Have you ever been tested for or found positive for a Patent Foramen Ovale or Atrial Septal Defect?

◯ Yes ◯ No

Do you suffer from migraines? ◯ Yes ◯ No

Please <u>check</u> if you have recently experienced any of the following:

◯ Night Sweats ◯ Unexplained Weight Loss ◯ Persistent Cough

◯ Loss of Appetite ◯ Fever ◯ Hemoptysis (coughing up blood)

◯ Chest Pain ◯ Shortness of Breath ◯ Palpitations

South Shore Vein
24 Maple Ave, Suite 2
Rockville Centre, NY 11570

T: 516-865-1234
southshorevein.com