Sharon Hammond M.D. **Mandi Phillips NP**
4500 E 9th Ave. Suite 615 · Denver CO 80220 · Phone 720.475.8750 · Fax 303.321.0367

NEW PATIENT EVALUATION

Patient name: _____

DOB: _____ Insurance: _____

PCP: _____Referring Provider: _____

COMPLAINT / HISTORY OF PRESENT ILLNESS (circle the symptoms you are experiencing)

☐ Burning ☐ itching ☐ heaviness/fatigue ☐ numbness ☐ throbbing ☐ dry skin ☐ impaired mobility
☐ painful /bleeding varicosities ☐ edema/swelling ☐ cramps ☐ restless legs ☐ active ulcers ☐ skin changes/discoloration

Aches/pain- please specify in pain scale from 0-10 (0 is no pain - 10 is the greatest pain you experienced) Where you would rate your pain _____

Symptoms are located: _____ Symptoms began: _____

CHECK ALL THAT APPLY: **** *You must mark **NO** or **N/A** if it doesn't apply*****

☐ _____ Symptoms are worse on the left
☐ _____ Symptoms are worse on the right
☐ _____ Symptoms are slightly better after leg elevation and/or walking
☐ _____ Symptoms are worse after prolonged sitting or standing
☐ _____ Difficulty sitting for more than _____minutes
☐ _____ Difficulty standing for more than _____ minutes
☐ _____ Difficulty walking for more than _____minutes

Compression stockings ☐ yes ☐ no When did you start _____ How many hours a day_____
How did it help? _____

Elevate legs ☐ yes ☐ no When did you start _____ How much time a day_____

NSAIDS (ex. Advil) ☐ yes ☐ no When did you start _____ Strength/# _____ How often do you take them_____

Weight reduction ☐ yes ☐ no # lbs. lost _____ How long has your weight been reduced _____

Exercise/walking ☐ yes ☐ no When did you start _____ Do you exercise daily___ For how long_____

Avoidance of prolonged standing ☐ yes ☐ no When did you start _____

Other life style modifications: _____

Patient Name: _____

D.O.B: _____

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How does your symptoms interfere with these activities of daily living. For instance, do you need to take breaks, if so, how long and how often do you take a break? Have you had changes in wearing shoes, clothing, sleeping habits, or any other, if so, for how long? **** *You must mark **NO** or **N/A** if it doesn't apply* ****

Cooking/cleaning _____

Dressing/grooming _____

House chores_____

Sleeping _____

Performing my job _____

Others-please specify: _____

Previous vein treatment- please specify_____

MEDICATIONS: **** You must mark **NO** or **N/A** if it doesn't apply**** ☐

List all medicines, steroids, inhalers, supplements (prescription or over-the-counter) you are currently taking:

Medication	Dosage	Frequency	Route (Oral, Inj.,Patch etc.)

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MEDICAL HISTORY (check all that apply)

___ No medical problems

___ Coronary artery disease (CAD)

___ Peripheral Arterial Disease (PAD)

___ History of Stroke

___Peripheral neuropathy

___ Hypertension

___ Hyperlipidemia

___Hyperthyroidism

___History of Cancer

___ Atrial Fibrillation/Arrhythmia(irregular heart beat)

___Diabetes

___Hepatitis A B C

___ Benign prostate hypertrophy

___Asthma

___Osteoporosis

___COPD

___DVT

___Hypercoagulable states

___ Lupus

___Spinal problem (back problem low back pain)

OTHER: _____

_____

ALLERGIES (list allergies and reactions or circle none) NONE ☐

ALLERGIC TO: REACTION:

_____ _____

_____ _____

_____ _____

Are you allergic to Latex? Yes ☐ No ☐

Have you had problems with general anesthesia? ☐No ☐I don't know ☐Yes- explain: _____

_____

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ADVANCED CARE PLAN

Do you have an Advanced Care Plan? ☐ Yes ☐ No

If YES, please provide the name and contact information for you surrogate decision maker (below):

_____

_____

SURGICAL HISTORY (please list any surgeries and the date)

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS (other than surgery)

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY Please indicate if any family member has had any of the following:

Medical condition	Family Member (s)
Diabetes	
Blood Pressure/Hypertension problems	
Elevated cholesterol	
Cancer (type:	
Heart problems/Chest pain	
Stroke/TIA	
Bleeding problems	
Blood clots	
Varicose veins	
Reaction to anesthesia	
Other:	

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SOCIAL HISTORY

Alcohol use: ☐ no alcohol ☐ drinks ____ per week ☐ drink occasionally

Tobacco use: ☐ never smoked ☐ former smoker ☐ currently smoke _____ daily

Recreational drug use: _____

Special diet - please specify:_____

Exercise program-please specify: _____

Occupation: _____ ☐ working full time ☐ working part time ☐ retired

Marital status: _____

Children: ☐ No ☐ Yes - How many: _____

REVIEW OF SYSTEMS (circle all that apply)

General: ☐ fever /chills ☐ weight change ☐ change in appetite ☐ night sweats

Dermatology: ☐ acne ☐ rash ☐ concerning lesions ☐ eczema ☐ hives ☐ mole ☐ nail changes

HEENT: ☐ visual changes ☐ drainage in ear ☐ runny nose ☐ sneezing ☐ sore throat ☐ trouble swallowing

Respiratory: ☐ cough ☐ chest pain with breathing ☐ shortness of breath on exertion ☐ sputum ☐ wheezing

Cardiology: ☐ chest pain with exertion ☐ murmurs ☐ palpitations ☐ irregular heart rhythm

Gastroenterology: ☐ bloating ☐ blood in stool ☐ change in bowel habits ☐ cirrhosis ☐ reflux ☐ abdominal pain

Genitourinary: ☐ blood in urine ☐ pain on urination ☐ incontinence ☐ penile/vaginal discharge

Musculoskeletal: ☐ joint pain ☐ joint redness ☐ joint swelling ☐ injury: _____

Neurology: ☐ confusion ☐ memory loss ☐ dizziness ☐ seizures

Psychology: ☐ anxiety ☐ depression ☐ excessive worry ☐ problem focusing ☐ irritability ☐ poor concentration

Hem/Lymph: ☐ anemia ☐ bleeding ☐ easy bruising ☐ enlarged lymph nodes ☐ chills

Endocrinology: ☐ hair loss ☐ hot flashes ☐ intolerance to cold/heat ☐ excessive drinking of water ☐ weight change ☐ sexual dysfunction

Last influenza immunization: _____ Last pneumonia immunization: _____