



**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 \_\_\_\_\_

CVS \_\_\_\_\_

RESP \_\_\_\_\_

GI \_\_\_\_\_

GU \_\_\_\_\_

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? Yes No
If yes, for what reason?
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)? Yes No
If yes, which leg and when?
4. Have you ever had phlebitis (inflammation of a vein)? Yes No
If yes, which leg and when?

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 \_\_\_\_\_