XRC
X-RAY CONSULTANTS, INC.

Mishawaka
611 East Douglas Road, Suite 207
Mishawaka, IN 46545
574-272-5347

Plymouth
1919 Lake Ave., Suite 107B
Plymouth, IN 46563
574-272-5347

Welcome to the XRC! Thank you for choosing our practice to meet your healthcare needs.

Please fill out the enclosed demographic and history forms prior to your appointment on:

____

Please bring all of these completed forms, along with your insurance identification card(s) and a photo ID, such as your driver's license, to your appointment.

Our facility is located in the Plymouth Medical Office Building 2.
1919 Lake Ave Suite 107B, Plymouth IN 46563.

Please see enclosed map.

During your care you may receive a Patient Satisfaction Survey. We ask that you take a few minutes to let us know you were satisfied with our services. Your opinions are important to us!

We look forward to seeing you at your appointment. If you have any questions in the meantime, please do not hesitate to call or email me.

Sincerely,

Sharon Osthimer
574.272.5347
574.272.8617, fax
sosthimer@xrcmi.com

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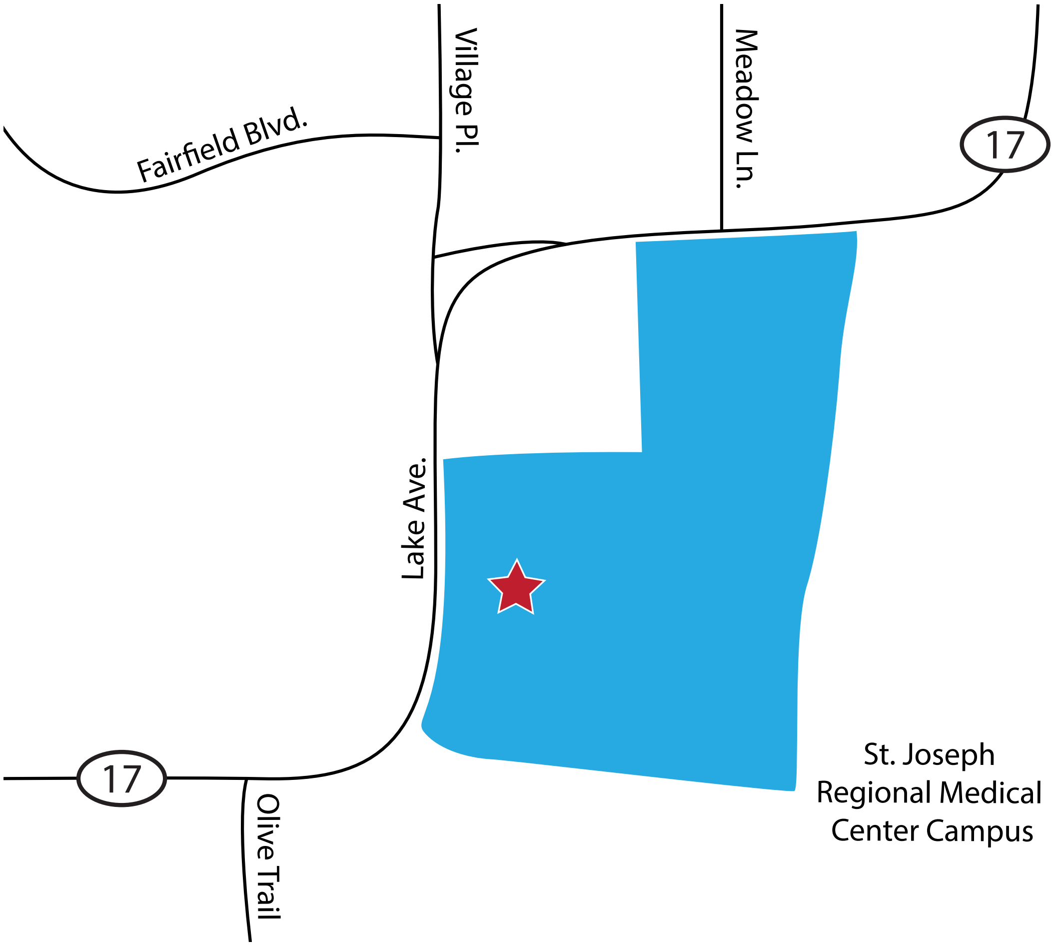

LEGACY
VEIN CLINIC
A Division of X-Ray Consultants, Inc.

Patient Intake Form – Venous History

Patient Name: ________________________ Date of Birth: __________ Referred by: ______________

Address: __________________________________ City/State: ______________ Zip: ____________

Gender: M___ F___ Marital Status: ________________ **Email Address: ________________________

Race: American Indian___ Asian___ Black/African American___ Hawaiian/Pacific Islander___ White___

Ethnicity: Hispanic___ Non-Hispanic___

Smoking Status: Daily___ Some___ Former___ Never___

Environmental Allergies: ____

____

Medication Allergies: ____

____

Primary Care Physician: ____

Medications Currently Taking

Medication: ____________________ Dosage: ______ Frequency: _______ Prescribed by: ____________

Medication: ____________________ Dosage: ______ Frequency: _______ Prescribed by: ____________

Medication: ____________________ Dosage: ______ Frequency: _______ Prescribed by: ____________

Medication: ____________________ Dosage: ______ Frequency: _______ Prescribed by: ____________

Medication: ____________________ Dosage: ______ Frequency: _______ Prescribed by: ____________

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Preferred Pharmacy: ________________________

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Patient Name: ______________________________ Date of Birth: ______________

Please indicate in which leg you have the following symptoms:

	Left Leg	Right Leg
Edema (swelling)	______________	______________
Pain location	______________	______________
Tiredness/Heaviness	______________	______________
Ulceration	______________	______________
Skin Color Changes	______________	______________
Spider Veins	______________	______________
Varicose Veins	______________	______________
Spontaneous bleeding from veins	______________	______________

How long have you had vein symptoms in your legs?______________ , months or years?

See the list below, please check the box next to the ADL (activity of daily living) that is limited by your leg symptoms and explain below:

Basic ADLs

Basic ADLs consist of self-care tasks that include, but are not limited to:

- ☐ Functional mobility, often referred to as "transferring" (moving from one place to another while performing activities)
- ☐ Bathing and showering (washing the body)
- ☐ Dressing
- ☐ Self-feeding (not including cooking or chewing and swallowing)
- ☐ Personal hygiene and grooming (including brushing/combing/styling hair)
- ☐ Toilet hygiene (getting to the toilet, cleaning oneself

Instrumental and other ADLs

Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they let an individual live independently in a community:

- ☐ Housework
- ☐ Preparing meals
- ☐ Shopping for groceries or clothing
- ☐ Care of pets
- ☐ Transportation within the community
- ☐ Home establishment and maintenance
- ☐ Religious observances
- ☐ Health management and maintenance
- ☐ Care of others (including selecting and supervising caregivers)
- ☐ Child rearing or caring for grandchildren
- ☐ Safety procedures and emergency responses
- ☐ Other: ______________________________
____

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1. Have you had any prior treatment for varicose veins? . . . . Yes___ No___
If yes, dates of treatment_______________________________

2. Do you have any history of ulcerations? . . . . Yes___ No___
If yes, have they improved over time? . . . . Yes___ No___

3. Have you ever had clots in veins or deep vein thrombosis? . . . . Yes___ No___

4. Do you wear support stockings/hose? . . . . Yes___ No___
If yes, are they prescription___ or over-the-counter___?
If yes, are they knee high___ or thigh high___?
How long have you worn them?_______________________________
Have symptoms improved? . . . . Yes___ No___

5. Do you take pain medication for your varicose/spider veins . . . . Yes___ No___
If yes, does the medication help? . . . . Yes___ No___

6. Do you elevate your legs to relieve your symptoms? . . . . Yes___ No___
If yes, does elevating your legs help? . . . . Yes___ No___

7. Are your symptoms worse at the end of the day? . . . . Yes___ No___

8. What other things do you do to alleviate symptoms?____

9. Have you ever gone to the emergency room because of your varicose veins? . . . . Yes___ No___

10. Do you have any family history of varicose/spider veins? . . . . Yes___ No___
If yes, relationship to you_______________________________

11. Are you presently employed? . . . . Yes___ No___
If yes, what is your position?_______________________________

Do you sit or stand for long periods of time? . . . . Yes___ No___
If yes, how many hours per day?___
How do your symptoms affect your ability to perform your job?____

13. Are you currently or have you been on any hormone therapy or birth control pills? . . . . Yes___ No___
If yes, please list____

14. Have you ever taken the acne drug Dynacin, Minocin or Minocycline? . . . . Yes___ No___
If yes, please list____

15. Do you experience pelvic pain or fullness? . . . . Yes___ No___

16. Do you experience migraine headaches? . . . . Yes___ No___

17. Have you ever had a reaction to anesthesia? . . . . Yes___ No___

18. Do you have a heart defect? . . . . Yes___ No___
If yes, please describe____

19. Have you had ANY pregnancies? . . . . Yes___ No___
If yes how many?___
Did symptoms worsen after pregnancy? . . . . Yes___ No___

20. Are you currently pregnant? . . . . Yes___ No___

21. Are you currently nursing/breast feeding? . . . . Yes___ No___

22. Do you have or have you had vulvar varicosities? . . . . Yes___ No___

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Patient Demographics

Last Name	First Name	Middle Initial
Patient's Date of Birth	Patient's Social Security Number	
Street Address		
City	State	Zip Code
Home Phone	Cell Phone	Work Phone
Employer	Employer Address	
City	State	Zip Code

Responsible Party *(ONLY if the person who carries the insurance is NOT the patient)*

Last Name	First Name	MI
Responsible Party's Date of Birth	Responsible Party's Social Security Number	

*****PLEASE LIST YOUR REFERRING, FAMILY OR OTHER DOCTOR'S NAME IF YOU WOULD LIKE THEM TO RECEIVE INFORMATION ABOUT YOUR CARE FROM OUR OFFICE*****

Doctor 1

Doctor 2

Doctor 3