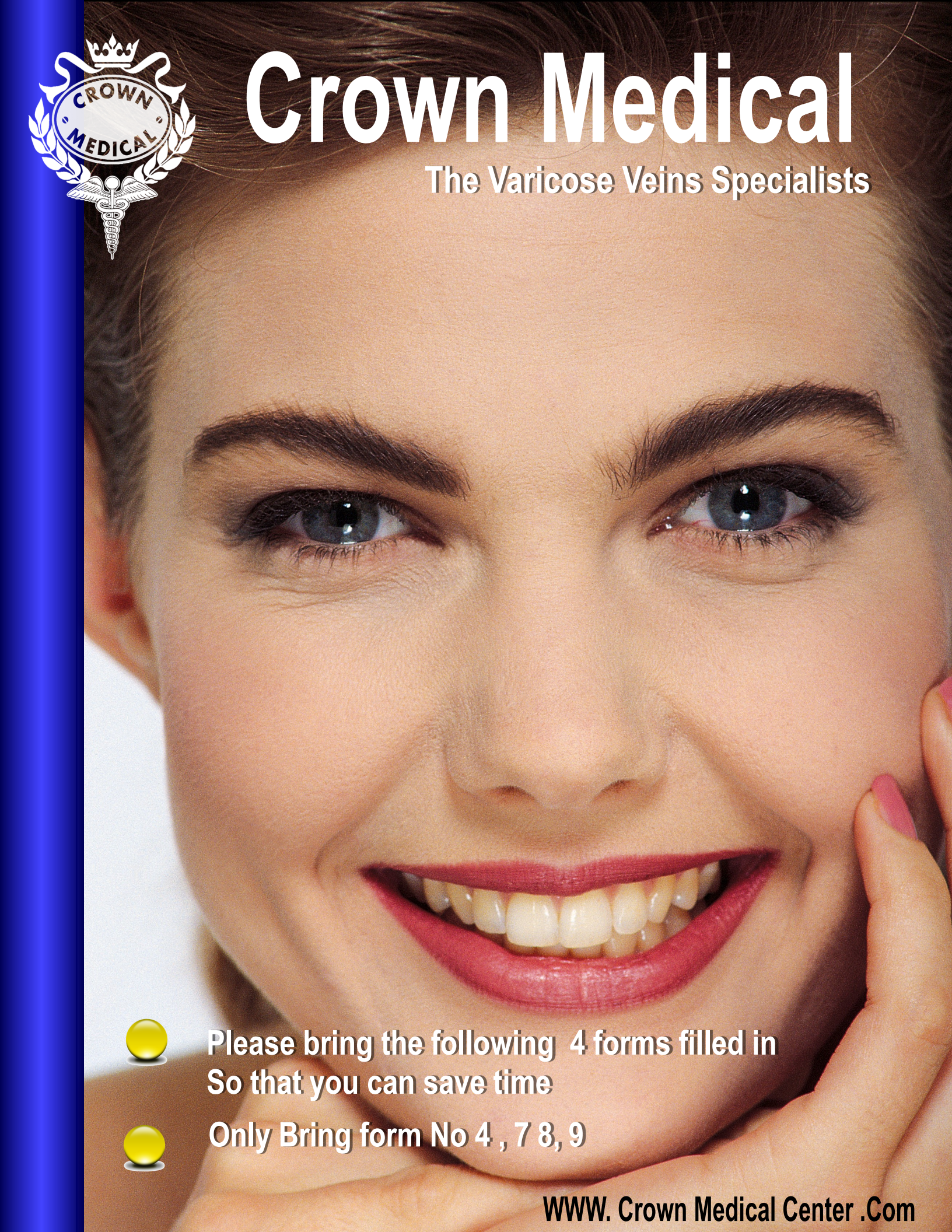

Crown Medical
The Varicose Veins Specialists
Please bring the following 4 forms filled in
So that you can save time
Only Bring form No 4 , 7 8, 9
WWW. Crown Medical Center .Com


Congratulations ,
You have taken the
First Step to Beautiful
Legs,
Calling
CROWN
MEDICAL

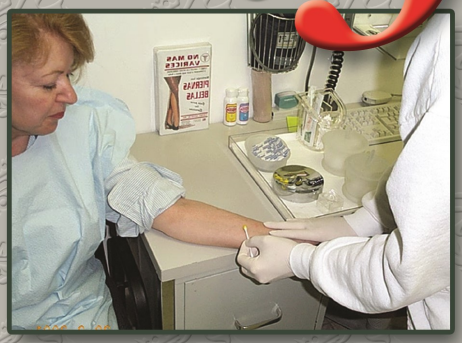
Crown Medical , The Varicose Veins Specialist

WHAT WILL HAPPEN IN YOUR FIRST VISIT

1 *Comprehensive Medical Evaluation*

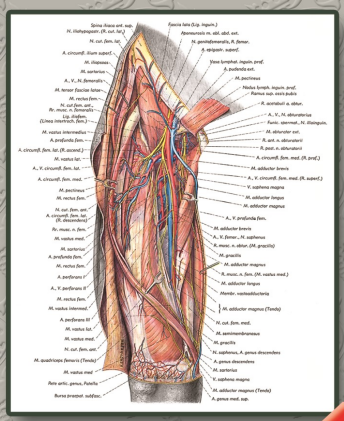
2 *Computerized Evaluation of your legs and thighs*

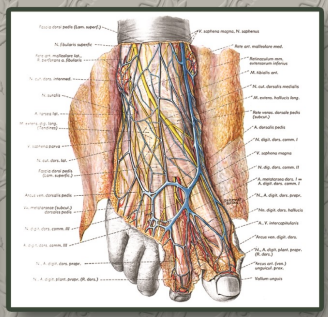
Skin Coloration and allergy Testing **3**



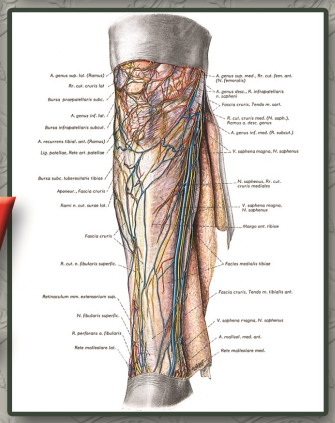
STEPS THAT YOU WILL GO THROUGH IN YOUR FIRST VISIT

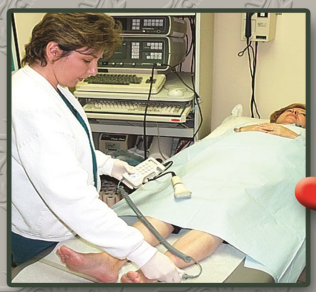
Venous Map





4 *Complete Venous Evaluation*





5 *Doppler Testing (If needed)*

6 *Speeial Treatment Plans Prepared for your needs and Speeific Charaeteristics*

7 *Discussion and analysis of your Treatment Plan*

CROWN MEDICAL
A Management Services Co.

PATIENT MEDICAL INFORMATION

Name: _____ Age: ____ Sex: ____ Height: ____ Weight: ____

Symptoms and Conditions

Please mark all present symptoms and/or conditions that have made you visit our office.

☐ Varicose Veins ☐ Leg Cramps ☐ Leg Swelling ☐ Leg Numbness ☐ Leg Pain
☐ Swelling of the Ankles ☐ Pain standing or walking ☐ Leg Ulcers ☐ Dermatitis
☐ Swollen Veins ☐ Pigmentation ☐ Inflammation ☐ Other: _____

1. Do you have any other illnesses, besides varicose veins? _____
2. When was the first time you noticed your varicose veins? _____

Social History

3. What is your Marital Status? ☐ Married ☐ Divorce ☐ Widowed ☐ Single
4. Do you smoke? ☐ Yes ☐ No If Yes, How many packs a day? _____
5. What type of work do you do? _____
6. How would you classify your relationship with your family? ☐ Good ☐ Fair ☐ Poor
7. Do you drink alcohol? ☐ Yes ☐ No If Yes, How many glasses a day? _____
8. How would you classify your relationship with your co-workers? ☐ Good ☐ Fair ☐ Poor
9. Where were you born? _____ How long have you been in the USA? _____

Past Medical History

10. What childhood illnesses did you have? _____
11. Have you had any type of surgery? ☐ Yes ☐ No Type of procedure: _____
12. Have you been hospitalized in the past? ☐ Yes ☐ No Reason: _____
    Date: _____ Hospital: _____
13. Have you had any physical accidents? ☐ Yes ☐ No Explain: _____

Allergies

14. What type of allergies do you have? _____
    Are you allergic to any medications? ☐ Yes ☐ No List: _____
    Are you allergic to any foods? ☐ Yes ☐ No List: _____

Present Medications

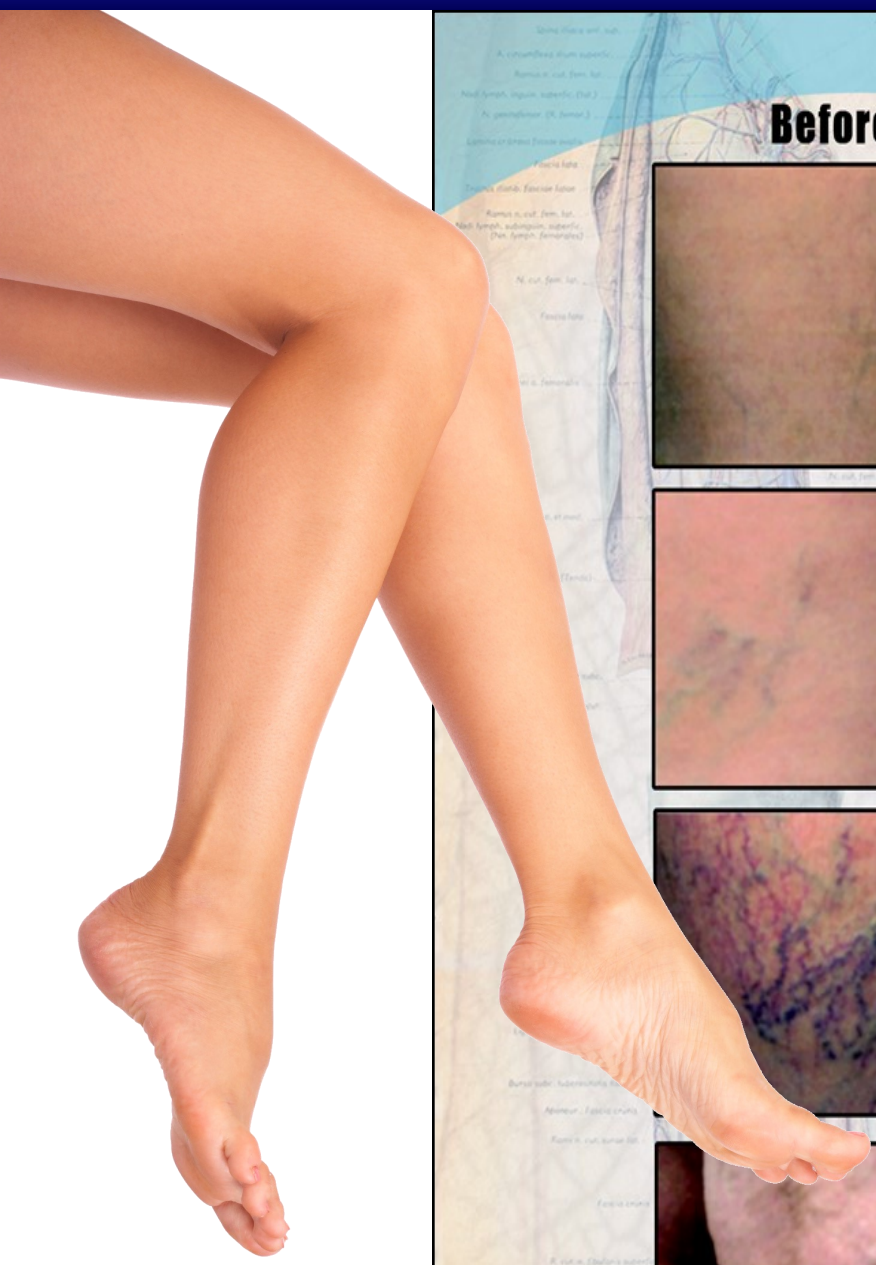
15. What medications are you taking? List: _____

Family Medical History

16. Does anyone in your family have varicose veins? ☐ Yes ☐ No Who: _____

Date: _____ **Patient Signature:** _____

Results Obtained at Crown Medical



CROWN MEDICAL
A Management Services Co.

INFORMACIÓN MEDICA DEL PACIENTE

Nombre: _____ Edad: ____ Sexo: ____ Estatura: ____ Peso: ____

Síntomas y Condiciones

Favor de marcar todos los síntomas y condiciones por lo que Ud. Asiste a nuestro centro.

☐ Venas Varicosas ☐ Calambres en las piernas ☐ Inflamación en la piernas ☐ Adormecimiento
☐ Dolor en las piernas ☐ Dolor estando parado(a) o caminando ☐ Dermatitis ☐ Ulceras
☐ Pigmentación en la piel ☐ Inflamación en los tobillos? ☐ Otros: _____

1. Además de varices tiene Ud. Alguna otra enfermedad? _____
2. Cuándo fue la primera vez que se noto las varices? _____

Historia Social

3. Cuál es su estado civil? ☐ Casado(a) ☐ Divorciado(a) ☐ Viudo(a) ☐ Soltero(a)
4. Ud. fuma? ☐ Si ☐ No Cuantos paquetes al día? _____
5. Que tipo de trabajo hace? _____
6. Cómo clasifica su relación con su familia? ☐Buena ☐ Regular ☐ Mala
7. Toma Ud. Alcohol? ☐ Si ☐ No Cuantas copas al día? _____
8. Cómo clasifica su relación en el trabajo? ☐ Bien ☐ Regular ☐ Mala
9. En que país nació Ud.? _____ Que tiempo hace que vive en USA? _____

Historia Medica Pasada

10. Que enfermedad tuvo de niño(a)? _____
11. Ha tenido algún tipo de cirugía? ☐ Si ☐ No Tipo: _____
12. Ha estado hospitalizado(a) alguna vez? ☐ Si ☐ No Razón: _____
    Fecha: _____ Hospital: _____
13. Ha tenido algún tipo de accidente? ☐ Si ☐ No Cual: _____

Alergias

14. Tiene Ud. Algún tipo de alergia? _____
    Alérgico(a) a algún tipo de medicamento? ☐ Si ☐ No Cuales: _____
    Alérgico(a) a algún tipo de comida? ☐ Si ☐ No Cuales: _____

Medicamentos

15. Esta tomando algún tipo de medicamento? Cuales: _____

Historia Medica Familiar

16. Alguien en su familia padece de varices? ☐ Si ☐ No Quien: _____

Fecha: _____ **Firma Del Paciente:** _____

2 WHAT STAGE ARE YOUR VARICOSE VEINS IN ?

Name :_____ Age :_____ Sex :_____Phone No :_____

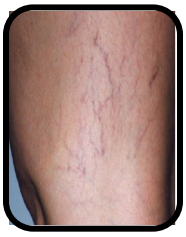
Based on the following photos, compare it to your varicose veins and mark in the corresponding photo which type you have. Remember you could have different types.

Level A

Grade 1

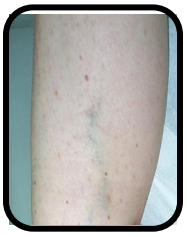
[ ] Yes, Qty:___

Grade 2



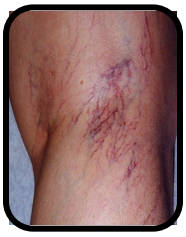
[ ] Yes, Qty:___

Grade 3



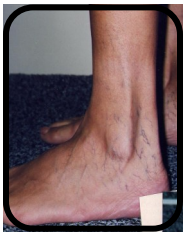
[ ] Yes, Qty:___

Grade 4



[ ] Yes, Qty:___

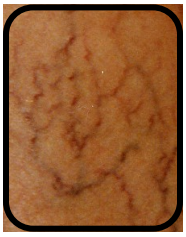
Grade 5



[ ] Yes, Qty:___

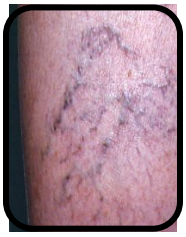
Level B

Grade 6



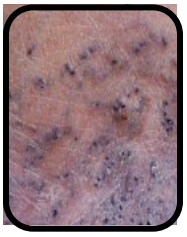
[ ] Yes, Qty:___

Grade 7



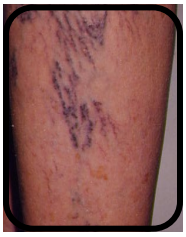
[ ] Yes, Qty:___

Grade 8



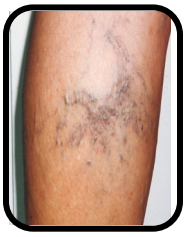
[ ] Yes, Qty:___

Grade 9



[ ] Yes, Qty:___

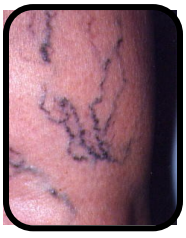
Grade 10



[ ] Yes, Qty:___

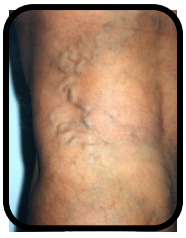
Level C

Grade 11



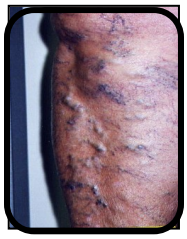
[ ] Yes, Qty:___

Grade 12



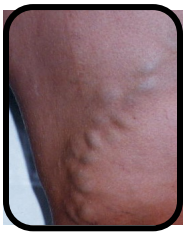
[ ] Yes, Qty:___

Grade 13



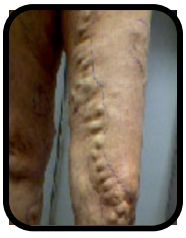
[ ] Yes, Qty:___

Grade 14



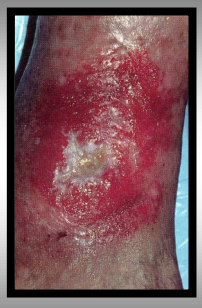
[ ] Yes, Qty:___

Grade 15

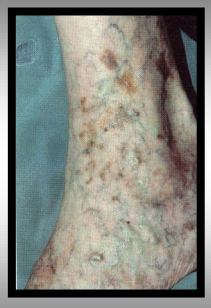


[ ] Yes, Qty:___

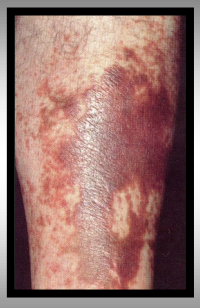
Level D



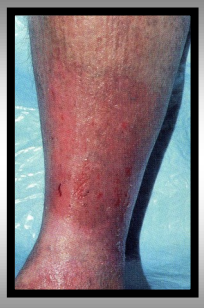
[ ] Yes, Qty:___



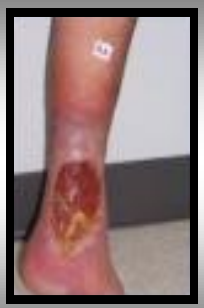
[ ] Yes, Qty:___



[ ] Yes, Qty:___



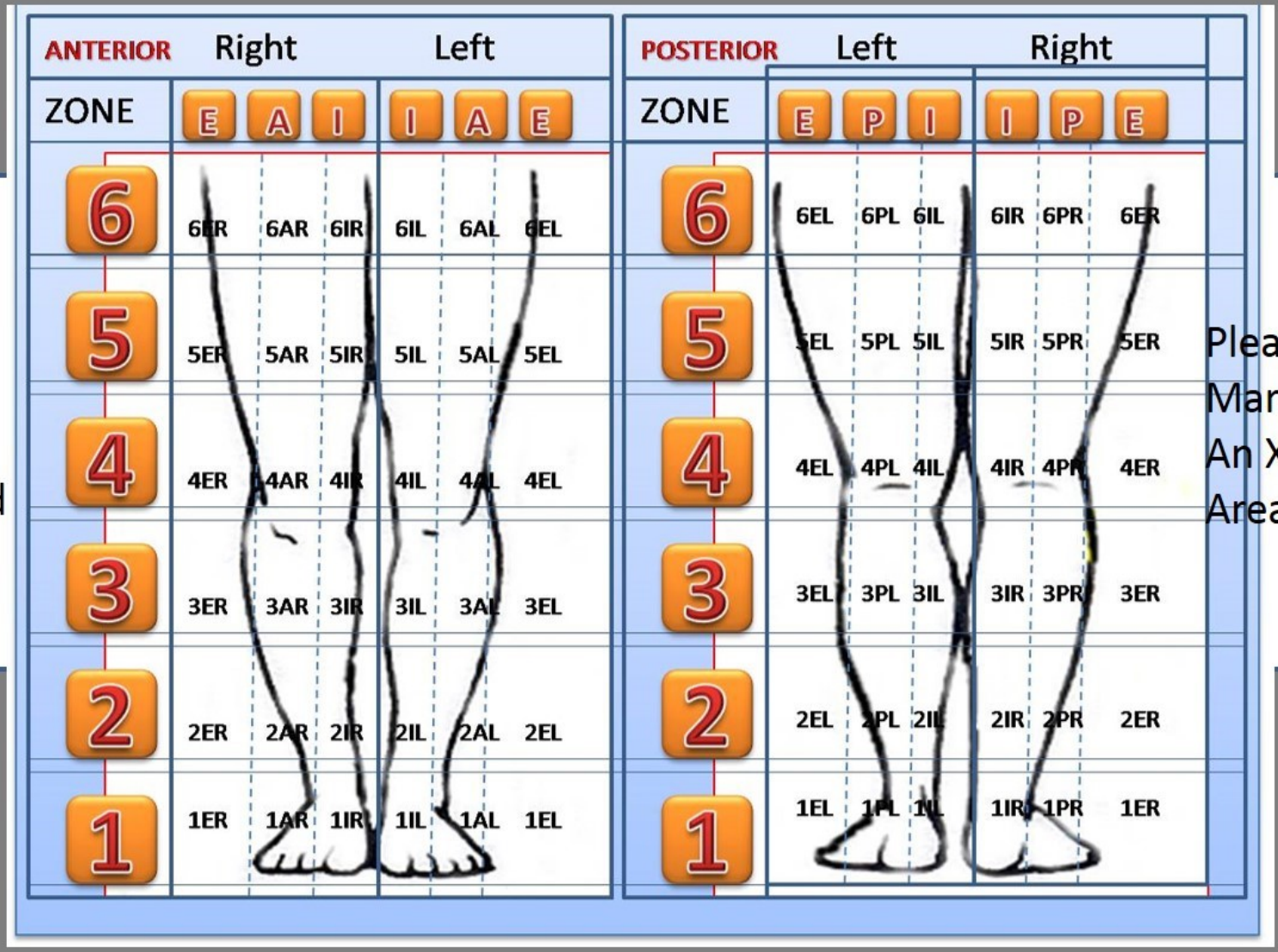
[ ] Yes, Qty:___



Crown Medical

Patient Name :_____ Date:_____

Please Mark with An X the Areas Affected

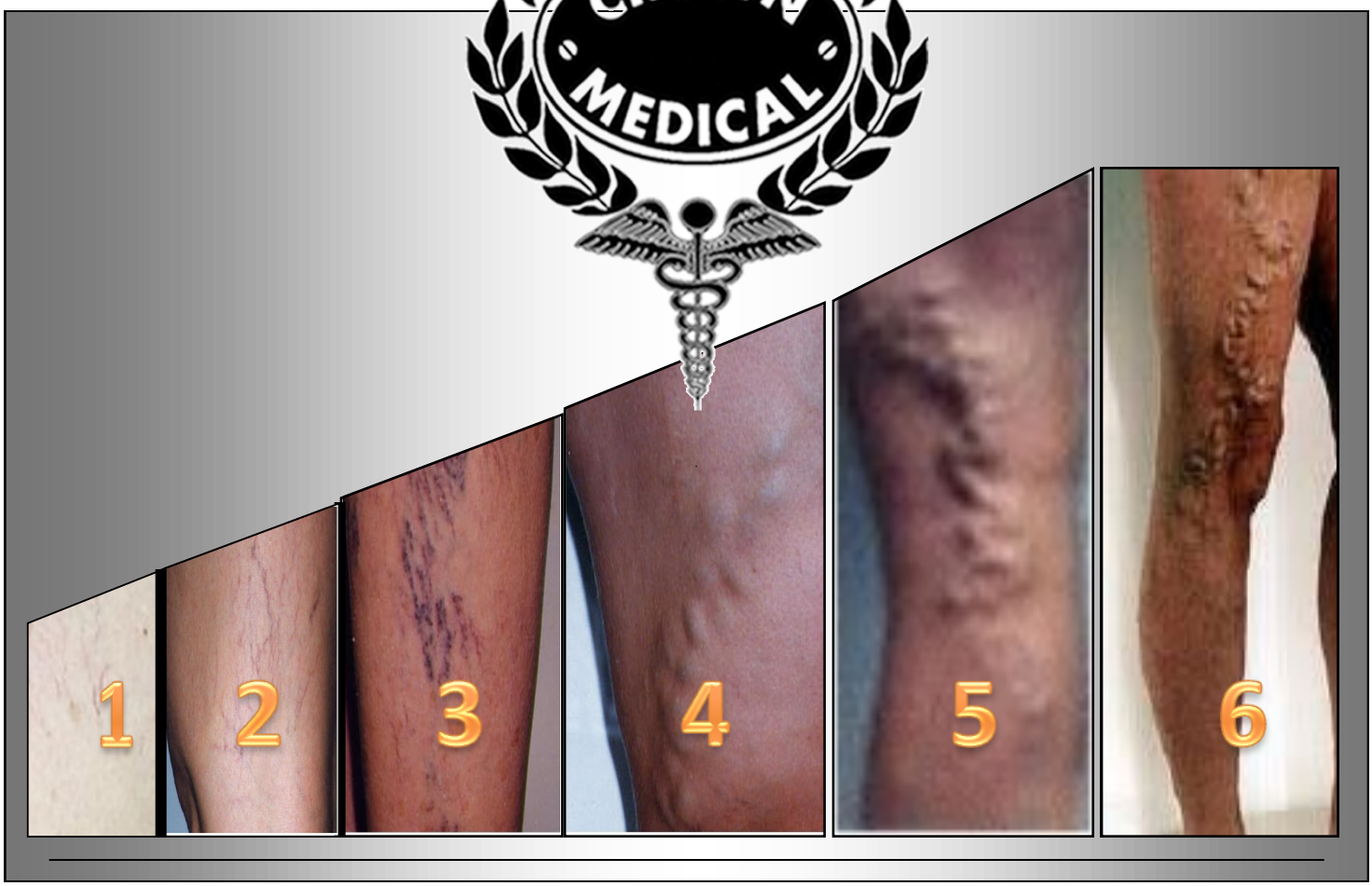


Please Mark with An X the Areas Affected

Please mark with an X on top of each section if it applies to your case

Patient Name :_____

Date :



BENEFITS

- Protect your Heath
- Avoid Ulcer formation
- Improve Skin
- Eliminate Pain in Legs
- Eliminate Cramp
- Avoid Swelling
- Eliminate Inflammations
- Improve your Mobility
- Avoid Surgery
- Avoid Hyper pigmentation
- Look Younger & feel Healthier

Don’t wait , Call today, Start looking and feeling much younger and healthier again

CROWN MEDICAL