

The logo for OC Vein Care features the letters 'OC' in a bold, orange, sans-serif font, followed by the words 'Vein Care' in a black, serif font.

# OC Vein Care

## Patient Registration Information

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**Maraya Altuwaijri M.D. R.P.V.I**

Board certified by the American College of General Surgery  
Board certified by the American College of Vascular Surgery

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**OC VeinCare**  
**Maraya Altuwaijri, M.D., R.P.V.I.**

**Receipt of Notice of Privacy Practices**  
**Written Acknowledgement Form**

I, \_\_\_\_\_, have reviewed a copy of Dr.Altuwaijri's Notice of Privacy Practices. I will indicate below my preference for communication with this office:

- I would like to have a copy of the Notice of Privacy Practices.
- I would **not** like to have a copy of the Notice of Privacy Practices.
- I would like you to call me at **home** for confirmation/results/other  
 Leave a message **Do not** leave message Home: ( ) \_\_\_\_\_
- I would like you to call me at work for confirmation/results/other  
 Leave a message **Do not** leave a message Work: ( ) \_\_\_\_\_
- I would like you to call me on my **cell** for confirmation/results/other  
 Leave a message **Do not** leave a message Cell: ( ) \_\_\_\_\_
- I would like you to communicate with me via **email** regarding any nonemergency medical issues. **My email address** is : \_\_\_\_\_
- I give my permission for Dr.Altuwaijri to discuss my medical condition with :**

Name	Relationship to me	Phone number
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Further, I understand that Dr.Altuwaijri and her staff will be contacting me by using the telephone numbers that I provide to this office-either by telephone, by writing, or in person which may be in addition to those I have listed above. As the patient, I am aware that it is my sole responsibility to inform the office of any telephone number changes. I will do so by telephone and or at the time of check in for my appointment.

\_\_\_\_\_  
**Patient signature**

\_\_\_\_\_  
**Date**

# VEIN SCREENING FORM

## Please complete left side of form only.

Date: \_\_\_\_\_ Appt Time: \_\_\_\_\_ Screening Provider: \_\_\_\_\_  
 Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Insurance Provider: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Sex:  M  F

### I. Vascular History

**Do you have or have you ever been diagnosed with:**

Varicose vein problems  Y  N Leg:  R  L  
 Phlebitis (vein redness/tenderness)  Y  N Leg:  R  L  
 Blood clots  Y  N Leg:  R  L  
 Deep vein thrombosis (DVT)  Y  N Leg:  R  L  
 Saphenous vein reflux  Y  N Leg:  R  L

**Do you experience any of the following in your leg(s):**

Aching/pain  Y  N Leg:  R  L  
 Heaviness  Y  N Leg:  R  L  
 Tiredness/fatigue  Y  N Leg:  R  L  
 Itching/burning  Y  N Leg:  R  L  
 Swelling  Y  N Leg:  R  L  
 Cramps  Y  N Leg:  R  L  
 Restless legs  Y  N Leg:  R  L  
 Throbbing  Y  N Leg:  R  L  
 Skin or ulcer problems  Y  N Leg:  R  L  
 Other:  Y  N Leg:  R  L

**Which of the following do you currently do to improve your leg vein symptoms:**

Medication for pain  Y  N What? \_\_\_\_\_  
 Elevation of legs  Y  N What? \_\_\_\_\_  
 Wear support hose  Y  N What? \_\_\_\_\_

### II. Family History

**Have any of your family members had:**

Varicose veins  Y  N Who? \_\_\_\_\_  
 Vein stripping  Y  N Who? \_\_\_\_\_  
 Blood coagulation disorder  Y  N Who? \_\_\_\_\_  
 Blood clots  Y  N Who? \_\_\_\_\_  
 Stroke, heart attacks or pulmonary emboli  Y  N Who? \_\_\_\_\_

### III. Vein Treatment History

**Have you ever been treated for varicose veins with:**

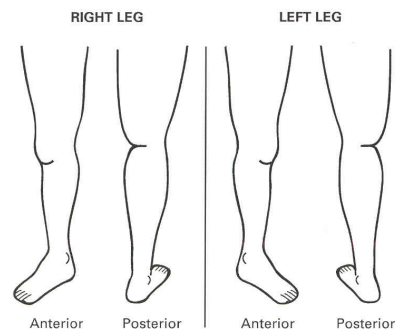
Sclerotherapy  Y  N Leg:  R  L  
 Laser therapy (spider veins)  Y  N Leg:  R  L  
 Phlebectomy  Y  N Leg:  R  L  
 Vein stripping surgery  Y  N Leg:  R  L  
 RF ablation (VNUS Closure®)  Y  N Leg:  R  L

### IV. Personal Activities List

**Does your work require:**

Prolonged standing periods  Y  N  
 Prolonged sitting periods  Y  N  
 Do you exercise regularly?  Y  N  
 Do you smoke?  Y  N  
 Pregnancies  Y  N How many? \_\_\_\_\_

### V. Vein Screening (to be completed by screening provider)



**Physical Exam:**

CEAP Clinical Signs:

**RIGHT LEG (check all that apply)**

No signs of venous disease  Spider veins  
 Visible varicose veins  Edema  
 Pigmentation  Healed ulcers  Active ulcers

**LEFT LEG (check all that apply)**

No signs of venous disease  Spider veins  
 Visible varicose veins  Edema  
 Pigmentation  Healed ulcers  Active ulcers

**Clinical Assessment:**

Chronic venous insufficiency  R  L  
 Other: \_\_\_\_\_  R  L

**Treatment Plan:**

Duplex ultrasound  R  L  
 Sclerotherapy  R  L  
 Medical compression stockings  R  L  
 Other: \_\_\_\_\_  R  L

Screening Provider Signature: \_\_\_\_\_

#### Follow-Up Appointment

Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 Physician: \_\_\_\_\_  
 Physician Phone Number: \_\_\_\_\_

NOTES:

**OC Vein Care**  
675 Camino de Los Mares, Suite 403  
San Clemente, Ca 92673

Name: \_\_\_\_\_  
\_\_\_\_\_

Date:

**Authorization for the Use of Photographs**

The use of photographs is essential to the planning and evaluation of cosmetic vein treatment and veins related to venous disease. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. Dr. Altuwaijri is often asked to show before and after photographs of her patients. Many patients, happy with their results, have given us permission to use their photos anonymously. We respectfully request that you do so as well.

Please consider the following circumstances and either authorize or deny use of your photographs for each situation.

\_\_\_\_\_ I authorize the anonymous use of my photographs for the purpose of assisting prospective patients who are in the process of choosing a surgeon and evaluating specific procedures performed by Dr. Altuwaijri.

\_\_\_\_\_ I authorize the anonymous use of my photographs by Dr. Altuwaijri for use in publications, seminars or conferences for prospective patients.

\_\_\_\_\_ I **do not** authorize the use of my photographs for any of the above reasons.

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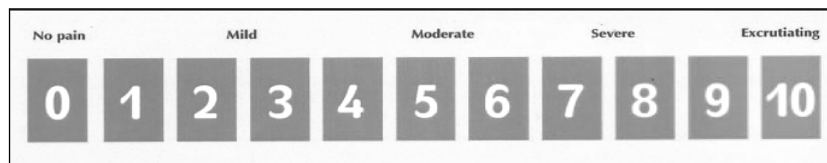
Patient Signature

Date



5. Do you experience any of the following in your legs?

- Aching/pain?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Heaviness?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Tiredness/fatigue?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Itching/burning?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Swollen ankles?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Leg cramps?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Restless legs?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs
- Throbbing?**  Yes During activity or prolong standing  Yes  No  LT / RT leg  Both legs



6. Have your veins gotten worse in recent months?  Yes  No

Describe: \_\_\_\_\_

7. Do you take any medication for pain (i.e., Advil, Motrin)  Yes  No  
If yes, what medication(s) do you take and how many times/mgs per day?

\_\_\_\_\_

8. How do you relieve your legs discomfort?  Yes  No

Leg elevation  Yes  No  
If yes, how long per day do you elevate and does it provide relief? \_\_\_\_\_

Exercise  Yes  No

Aspirin  Yes  No

Walking  Yes  No

Cold compress  Yes  No

Warm compress  Yes  No

Tylenol  Yes

No

Ibuprofen  Yes  No

Support stockings  Yes  No

Flex/extend legs  Yes

No

9. Do you exercise?  Yes  No  
If yes, what kind of exercise and how often?  
\_\_\_\_\_

Does walking or exercising relieve or worsen your leg discomfort? \_\_\_\_\_

*Most insurance companies require the use of graded compression stockings to be worn for a minimum of 6 weeks to 3 months before qualifying for varicose vein treatment.*

10. Have you ever worn prescription compression stockings?  Yes  No  
If yes, what type and gradient? How long have you worn them?  
\_\_\_\_\_

11. Do you wear light support hose (i.e., Sheer Energy)?  Yes  No  
If yes, do they provide relief?

12. Do you have any problem walking?  Yes  No  
If yes, describe how it interferes with your activities of daily living, which activities?  
(worse at night, after standing/sitting long periods or during/ after exercise)  
\_\_\_\_\_

13. What type of work do you do?  
\_\_\_\_\_

How long do you stand (hours per day) at work? \_\_\_\_\_

At home? \_\_\_\_\_

Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Have you ever had an ultrasound on your veins?  Yes  No  
If yes, when and which leg?  
\_\_\_\_\_  
\_\_\_\_\_

15. Were you diagnosed with saphenous vein reflux?  Yes  No

16. Name of referring Physician and how long have you been under his care for treatment of this condition?  
\_\_\_\_\_

17. Do you have any allergies to drugs or sensitivities to tape?  
If yes, list drugs or type of tape and reaction:  
\_\_\_\_\_

18. Do you have any current medical conditions you are being treated for?  
If yes, please list conditions: \_\_\_\_\_  
\_\_\_\_\_

19. List all medications you are taking (prescription, non-prescription, herbal medicines etc.) and dose
- 

**SOCIAL HISTORY:**

20. Do you smoke or consume alcohol?  
If yes, how much: \_\_\_\_\_  
Marital Status: married/single/ divorced/widowed
- 

**PATIENT MEDICAL HISTORY:**

Do you have a history of:

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Diabetes                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Peripheral Vascular disease     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid disease                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TIA (transient ischemic attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Carotid disease                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coronary heart disease          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver disease                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pulmonary embolus               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding disorder               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bruising                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney disease                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart valve disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leg trauma                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood transfusion               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- Type: \_\_\_\_\_  
Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:**

Include procedure and year: \_\_\_\_\_  
\_\_\_\_\_

**BLEEDING HISTORY**

- |                    |                              |                             |
|--------------------|------------------------------|-----------------------------|
| Aspirin use        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coumadin use       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bruising      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- 

**Review of systems:** (circle appropriate symptom)

**Constitutional symptoms:** Weight loss/gain/night sweats/fever

**Skin:** Change in skin color/mole/rash

**Eyes:** Glasses/contacts/change in vision/blurred vision/double vision

**Ear, nose, throat and mouth:** Ringing in ears/deafness/pain/sinus discharge/bleeding/hoarseness/discharge

**Cardiac:** chest pain/shortness of breath/palpitations/fatigue/leg swelling

**Respiratory:** Sputum production/coughing of blood/pain/cough

**Gastrointestinal:** Nausea/vomiting/vomiting of blood/indigestion/reflux/painful swallowing/diarrhea/constipation/yellow discoloration of skin/tarry stools/bloody stools/change in bowel habits

**Genitourinary:** Kidney/bladder disease/painful urination/decreased stream/bloody urine

**Musculoskeletal:** bone/joint deformity/limited motion/pain/weakness/trauma

**Neurological:** weakness/seizure/faints/paralysis/migraine/unsteady gait/headache/numbness in extremities

**Psychological:** hallucinations/anxiety/depression/bipolar

**Endocrine:** thyroid disease/sweating/tremor/change in appetite/constipation

**Hematological:** Bleeding disorders/thrombophilia/lymph node enlargement

**Immunological:** immune disorders/immunosuppression

**FEMALES:**

Are you currently breastfeeding? \_\_\_\_\_

Are you or could you be pregnant? \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

Hormone therapy: \_\_\_\_\_

Menopause: \_\_\_\_\_

Last mammogram: \_\_\_\_\_

Nipple discharge: \_\_\_\_\_

Lumps: \_\_\_\_\_

Cyclical pain: \_\_\_\_\_

Last pelvic examination: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_