iThriveVeins

<<< PATIENT MEDICAL RECORD >>>

PLEASE RETURN TO FRONT DESK

DxUS New Patient Form

Name: _____ Today's Date: _____ Phone #: _____

Date of Birth: _____ Height: _____ Approx. Weight: _____

Current Email Address: _____

Current HOME Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Relationship of Emergency Contact: _____

Primary Care Doctor: _____ PCP Phone Number: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Are you a Tobacco user: [ ] No [ ] Yes → [ ] Dip or [ ] Vape
Do you Smoke: [ ] No [ ] Yes → If YES, how many cigarettes per day? _____
Marijuana use and/or any other form of Cannabis? [ ] No [ ] Yes
Any illicit Drug uses? [ ] No [ ] Yes → If YES, what drugs do you do? _____
Alcohol consumption? [ ] No [ ] Yes → If YES, how many drinks per day? _____
Do you have any chronic condition(s)?

[ ] High Blood Pressure	[ ] Diabetes	[ ] Heart Disease
[ ] High Cholesterol	[ ] Thyroid Condition	[ ] AIDs

Past Surgical History: _____
Are you ALLERGIC to any medications? [ ] No [ ] Yes → If YES, List medication are you allergic too below:

_____

Any known food/environmental Allergy? _____
Are you currently on any medications (including over the counter)?
[ ] No [ ] Yes → If YES, please list your medications and the milligrams you take below:
_____
_____
_____

(Female Patients Fill out the Back)

iThriveVeins

<<< PATIENT MEDICAL RECORD >>>

PLEASE RETURN TO FRONT DESK

For Female patients ONLY:

What was the first day of your Last Menstrual Period? _____

Are you on Birth Control? [ ] Yes [ ] No Form of Birth control? _____

Have you had Tubal Ligation? [ ] Yes [ ] No
Partial or Full Hysterectomy? [ ] Yes [ ] No
Are you currently Pregnant? [ ] Yes [ ] No

Pregnancy History:
# of Total Pregnancies: _____
# of Miscarriages: _____
# of Living Children: _____
Full Term: [ ] No [ ] Yes → Comments: _____

Any additional information/comments?

_____

_____

_____

iThriveVeins

Medical Record Release Form

Patient's Name: _____ Date of Birth: _____/_____/_____

Phone Number: _____ Email: _____

Please release my medical records :

To / From Dr. Samir B. Damani
[ ] 650 Euclid Avenue, Suite 401 | National City, CA 91950
[ ] 9850 Genessee Ave, Suite 650 | La Jolla, CA 92037
Phone: 858-800-2480
Fax: 858-216-1908

To / From Name: _____

Address: _____

_____

_____

Phone #: _____ Fax # : _____

[ ] Please release all records; progress notes, operative notes, laboratory test results, diagnostic test results/reports.

[ ] Only release the following records: _____

_____

_____

_____

I hereby authorize the release of my medical records as indicated above.

_____
Patient's Signature

_____
Date