New York Medicine Doctors



800 2nd Avenue, 9th Floor New York, NY 10017 (212) 991-9991

Please indicate which services you may be interested in:

Botox	Yes	No
Cosmetic or Excessive Sweating	Yes	No
Anti - Aging	Yes	No
Micro - Needling / Facial Rejuvenation (younger looking skin)	Yes	No
Weight Loss	Yes	No
Balding (hair loss)	Yes	No
Neck, Back Pain Evaluation	Yes	No
Varicose Veins / Spider Veins	Yes	No
Hormone Replacement	Yes	No
Dermal Fillers (hands, face, neck)	Yes	No
Emsculpt - Body Toning (abs and buttoks lift)	Yes	No
Allergy Testing (food / environmental)	Yes	No

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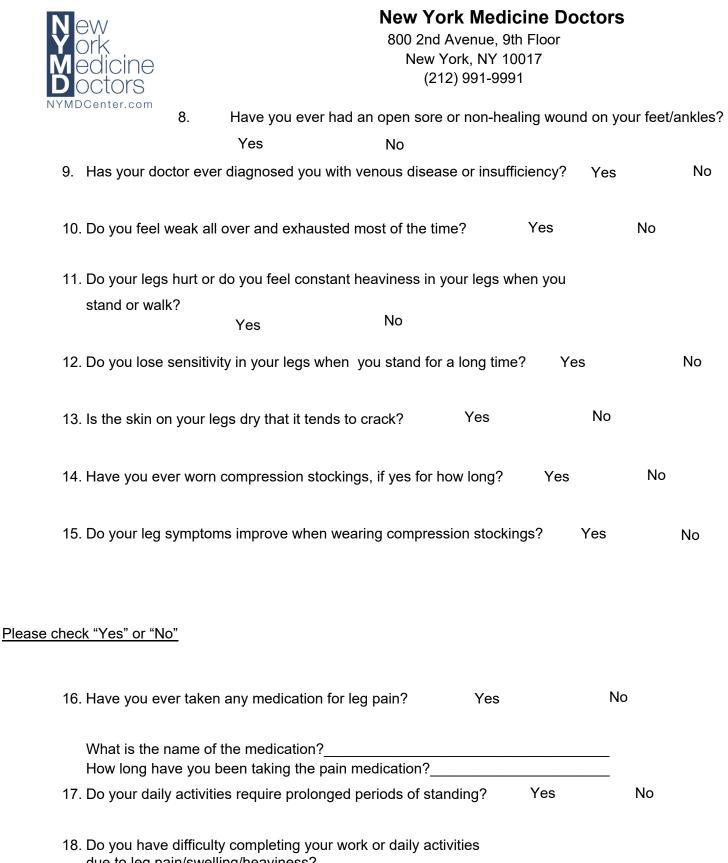
Patient Name:			
-			
Cell Phone:			

Please take a few minutes to answer the following questions about how your legs and feet feel.

Keep in mind how it affects your daily life.

Please check "Yes" or "No"

1.	Do your legs and / or feet get numb?	Yes	No	
2.	Are your legs and / or feet warm to touch?	Yes	No	
3.	Have you ever had burning pain and / or severe cramping in	your legs?	Yes	No
4.	Do you have spider veins and / or varicose veins?	Yes	No	
5.	Do you have persistent lower back and / or leg pain?	Yes	No	
6.	Have you developed any discoloration or color changes in y	our legs?	Yes	No
7.	Have you developed any previous vein treatment in the past	that failed?	Yes	No
If yes please check all the options that apply; 🖙 Laser ablation, 🕿 Sclerotherapy injections, 🛥 Stripping & ligation, 🕿 Phlebectomy				



due to leg pain/swelling/heaviness?

Yes



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19. Have you had recent:	📾 Heart Valve Diseas	e 👄 Heart	Murmur	
😅 Heart Valve Surgery				
20. Have you ever been diagn	osed with Peripheral Arteria	al Disease (PAD))? Yes	No
21. Have you ever been diagn	osed with blood clot or DT\	/? If so, where?	Yes	No
22. Have you or your family m	ember ever been diagnose	d with a clotting	disorder? Yes	No
23. If you are a female, are yo	u currently pregnant?	Yes	No	
24. Are you on any blood thinr	ners other than aspirin or pl	avix (clopidogre	l) Yes	No
If yes, which blood thinner	s are you on?			