Greenwich Health, PLLC
Julie Huang-Lionnet, MD
1472 Post Road, Darien, CT 06820
P: 203.900-3996 or 203.900.3995

Board Certified Anesthesiology
Subspecialty Certification in Interventional Pain Management
Certified in Venous, Regenerative and Cosmetic Medicine
F: 203.900.3998 or 203.902-0166 ▪ www.greenwichhealth.org

PATIENT COMPREHENSIVE QUESTIONAIRE

VENOUS MEDICINE

REFERRAL PROVIDER INFORMATION Date of Request: _____/_____/_____

Requesting Provider: _____ NPI#: _____

Phone #: (_____) _____ Fax #: (_____) _____

Primary Care Physician (*if different*): _____ NPI#: _____

Phone #: (_____) _____ Fax #: (_____) _____

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ Middle Name: _____

Gender: ☐ Male ☐ Female DOB: _____/_____/_____ Age: _____

Home Address: _____
City State Zip Code

Home Phone #: (_____) _____ Cell/Message Phone: (_____) _____

PATIENT EMPLOYER: _____ Work Phone: (_____)_____ Fax: (_____)_____

Work Address: _____
City State Zip Code

Occupation: _____

PHARMACY: _____ ADDRESS: _____
City State Zip Code

EMERGENCY CONTACT: _____RELATIONSHIP:_____ Phone #: (_____) _____

Nearest friend or relative not living with you, in case of emergency▼ **EMAIL ADDRESS:** _____

INSURANCE-PRIMARY

Name of Insurance: _____ ID#: _____ Group: _____

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____ Relationship: _____

Insured's Social Security #: _____-____-_____ Insurance Phone #: (_____)_____

Employer's Name: _____ Employer Address: _____
City State Zip Code

INSURANCE-SECONDARY

Name of Insurance: _____ ID#: _____ Group: _____

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____ Relationship: _____

Insured's Social Security #: _____-____-_____ Insurance Phone #: (_____)_____

Employer's Name: _____ Employer Address: _____
City State Zip Code

Other Notes/Information: _____

WELCOME!

GREENWICH HEALTH IS COMMITTED TO PARTNERING WITH YOU TO MAKE A DIFFERENCE.

We believe that the more you know about GREENWICH HEALTH, PLLC, the better we can partner with you to make a difference. So, please take a few minutes to read and become familiar with the following:

1. **OFFICE HOURS:**

Clinical Office	Tuesday (Darien, CT)	9:00 AM-5:00 PM
	Wednesday (New York, NY)	8:00 AM-3:00 PM
Administrative	Monday-Friday	9:00 AM-5:00 PM

2. **TELEPHONE CALLS:**
GREENWICH HEALTH, PLLC's Physician and clinical staff attempt to be thorough and complete during your visit, including answers to all of your questions. You will notice that the clinical staff will rarely be interrupted by the telephone during your visit (unless another doctor is calling.) This is because we ask our patients to respect one another's time by holding their questions until their scheduled visit. We encourage you to write down all of your questions so you will not forget.

   In other words, GREENWICH HEALTH, PLLC's Physician, nurse or medical assistants do not accept phone calls except in very unusual circumstances. If you have a clinical question that you believe can NOT wait until your regularly scheduled visit, you may call the office at (203)900-3996. Please, follow the prompts. Your question will be assessed and triaged according to the clinical significance then responded to accordingly. Please do **NOT** leave duplicate messages.

3. **CANCELLATIONS:**
Cancellations not made within 24 hours will be subject to a fee per payment and cancellation policy. Please contact our office to cancel or re-schedule with at least 24 hours' notice.

4. **PRESCRIPTIONS:**
All prescriptions must be picked up in person at a scheduled office visit, not on procedure appointment. For medications that can be called in, allow 4 working days to receive your prescription. Please call in your prescription request at (203) 900-3996.

   Patients who come in for pain management frequently must take medicines for a variety of ailments such as high blood pressure, diabetes, heart disease, etc. **You will need to fill these prescriptions through your Primary Care Provider.**

5. **INSURANCE:**
As a courtesy, GREENWICH HEALTH, PLLC will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards.
   - Many procedures that are performed by GREENWICH HEALTH, PLLC require preauthorization from your insurance carrier. It is not uncommon for authorization to require up to 10-14 days.
   - Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan.
   - If any changes in your insurance coverage or benefits occur while being treated at GREENWICH HEALTH, PLLC, you are responsible to notify us immediately.

6. **FINANCIAL POLICY:**
I understand that if I am not **ELIGIBLE** under the terms of my medical and hospital subscriber health insurance agreement, I am **LIABLE for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the Practice.

7. **CO PAY'S/DEDUCTIBLES:**
If your insurance coverage requires co-pay, it will be collected when you check in, before you see the physician provider. Deductibles are determined by your Insurance Company, GREENWICH HEALTH, PLLC will notify you of your responsibility after explanation of benefits are received.

8. **FORMS:**
GREENWICH HEALTH, PLLC requires that all types of forms be completed **during a scheduled office visit**. If you need a form filled out by the physician, please notify the scheduler of this fact. Fees are as follows:
   1st page $30.00 Each additional page $15.00

9. **OFFICE VISIT PRINTED RECORD**: Same day office visit medical record will be available upon request, please ask physician

10. **REFERRAL POLICY:**
GREENWICH HEALTH, PLLC is a specialty-based practice. Patients are scheduled upon referral only.

11. **PRIMARY CARE PHYSICIAN:**
If you are referred to GREENWICH HEALTH, PLLC by another specialist, it is imperative that you have a relationship with a **primary care physician**. Our physician serves as consultants and cannot assume the role provided by a primary care doctor.

12. **EMERGENCIES:**
Fortunately, there are very few medical emergencies related to venous medicine. However, if you believe you are experiencing such an emergency, you should go immediately to the nearest urgent care facility or emergency room. The physician attending to your problem in the urgent care facility or emergency room should be the one to call and communicate with your venous care specialist. You should request that physician to do so. Therefore, it is only in very unusual circumstances that an unscheduled or urgent visit is necessary.

Patient Printed Name: _____ Patient Signature: _____

Date: _____

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Patient Name: _____ **Date of Birth:** _____/_____/_____ **Date:** _____/_____/_____

Please tell us the problem you would like us to help you with, including symptoms and attach pertinent medical records, imaging, test results, and physician visits, including specialists (CC): Side: ☐Right ☐Left

_____

_____

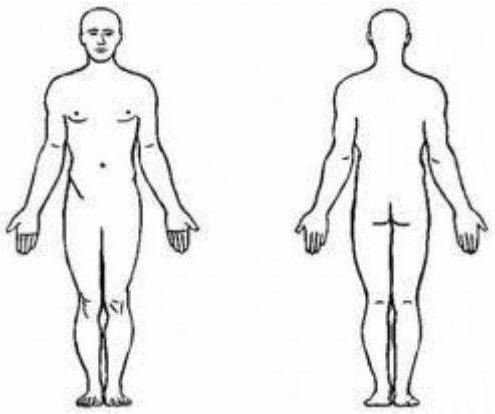
_____

Date of First Symptoms (Required by Insurance)**:** _____/_____/_____ ☐ Sudden ☐ Gradual

Your symptoms has been occurring for:_____ ☐ Days ☐ Weeks ☐ Months ☐ Years

SHADE IN OR CIRCLE WHERE YOU EXPERIENCE SYMPTOMS: (Please mark and check all that apply.)

FRONT BACK



RIGHT LEFT LEFT RIGHT

	R	*L*
Aching and Pain in the Legs	☐	☐
Heaviness	☐	☐
Tiredness and Fatigue	☐	☐
Itching / Burning / Warmth	☐	☐
Leg Cramping	☐	☐
Leg Restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐
Skin Color Changes	☐	☐

PLEASE INDICATE IF YOU HAVE TRIED ANY OF THESE CONSERVATIVE TREATMENTS AND IF THEY WERE EFFECTIVE

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF	DETAILS
PAIN MEDICATIONS	☐	☐	☐	_____
COMPRESSION STOCKINGS OR LEG WRAPS	☐	☐	☐	_____
STRENGTH OF STOCKINGS	☐ 15-20 mm Hg	☐ 20-30 mm Hg	☐ >30 mm Hg	☐ Other:_____
HOW LONG HAVE YOU TRIED?	_____			
ARE YOU OBTAINING RELIEF?	_____			
ARE YOUR PRODUCTS IN GOOD CONDITION?	_____			
EXERCISE/PHYSICAL THERAPY	☐	☐	☐	_____
WEIGHT REDUCTION	☐	☐	☐	_____
LEG ELEVATION	☐	☐	☐	_____
JOB CHANGE	☐	☐	☐	_____
OTHER (*EXPLAIN*):	_____	_____	_____	_____

*Initial:*_____

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Please list your weight: _____ lbs. and height: _____ ft. _____in.

PLEASE INDICATE **ANY ASSOCIATIONS WITH YOUR SYMPTOMS:**

	PLEASE MARK YES OR NO			
	YES	**NO**	**Unknown**	**EXPLAIN**
DO YOUR SYMPTOMS INTERFERE WITH YOUR SLEEP?	☐	☐	☐	_____
ARE YOUR SYMPTOMS WORSE LATER IN THE DAY?	☐	☐	☐	
ARE YOUR SYMPTOMS WORSE WITH OR AFTER ACTIVITY?	☐	☐	☐	_____
DO YOUR SYMPTOMS KEEP YOU FROM DOING ANYTHING?	☐	☐	☐	

**Symptoms causing depression or anxiety? YES/NO *(If YES, Explain)* _____	**Do you smoke tobacco? If NO, ☐ FORMER ☐ NEVER If YES, ☐ Since (date): ☐ Frequency: Date Quit:_____ #Packs/Day_____ Years_____
How many hours do you sleep? _____	**Do you drink alcohol? If NO, ☐ FORMER ☐ NEVER If YES, ☐ Since (date): ☐ Frequency:
How many hours per day you work? _____	**Do you do any recreational drugs? YES/NO *(If YES, Explain)*_____
How does symptoms limit your activities? *(If YES, Explain)* Work/school?_____ Household Chores?_____ Social Interactions?_____ Leisure?_____ Sexual Activity?_____	What is your current employment status? _____ Type of work? _____ Do you have pending a settlement of disability, workman's compensation, or a legal matter? YES/NO *(If YES, Explain)* _____

DO YOU HAVE ANY PERIPHERAL ARTERIAL DISEASE (PAD) SYMPTOMS? (CHECK ALL THAT APPLY)

	PLEASE MARK YES OR NO		
	YES	**NO**	**UNKNOWN**
WAS DIAGNOSED WITH PAD IN THE PAST	☐	☐	☐
HAVE/HAD CRAMPING LEG PAIN THAT WORSENS WITH WALKING, FORCING ME TO STOP WALKING	☐	☐	☐
FEET/TOES BECOME PALE AND PAINFUL WITH EXERCISE OR WHEN ELEVATING THEM	☐	☐	☐
HAVE/HAD ULCERS ON FEET OR TOES	☐	☐	☐

RESTLESS LEG SYNDROME (CHECK ALL THAT APPLY)

	PLEASE MARK YES OR NO		
	YES	**NO**	**UNKNOWN**
DO YOU FIND THE NEED TO MOVE YOUR LEG(S) TO RELIEVE AN UNCOMFORTABLE FEELING?	☐	☐	☐
DO(ES) YOUR LEG(S) FEEL BETTER WHEN MOVING IT (THEM) OR WALKING?	☐	☐	☐
ARE YOUR LEG SYMPTOMS WORSE WHEN SITTING OR RESTING, WITHOUT ELEVATING YOUR LEG(S)?	☐	☐	☐
ARE YOUR LEG SYMPTOMS WORSE LATER IN THE DAY OR NIGHT?	☐	☐	☐

*Initial:*_____

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PLEASE CHECK BELOW IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

VENOUS HISTORY	***EXPLANATION / DETAILS***
☐ *A prior evaluation for your veins: _____(yr)*	
☐ *Previous Vein Surgery or Laser Treatments:_____(yr)* ☐ *R* ☐ *L*	
☐ *Previous Vein Surgery or Laser Treatments-2:_____(yr)* ☐ *R* ☐ *L*	
☐ *Previous Vein Injections:_____(yr)* ☐ *R* ☐ *L*	
☐ *Previous Vein Injections-2:_____(yr)* ☐ *R* ☐ *L*	
☐ *Bleeding from a Vein:_____(yr)* ☐ *R* ☐ *L*	
☐ *A Leg Ulceration:_____(yr)* ☐ *R* ☐ *L*	
☐ *A Leg Ulceration-2:_____(yr)* ☐ *R* ☐ *L*	
☐ *Superficial Thrombophlebitis or an Inflammation of a Vein:* ☐ *R* ☐ *L* _____*(yr)* _____*(Location)*	
☐ *DVT / Blood Clot? If Yes, When?_____(yr)*	
☐ *R* ☐ *L* _____*(Location)*	
☐ *DVT / Blood Clot-2? If Yes, When?_____(yr)*	
☐ *R* ☐ *L* _____*(Location)*	
☐ *Any Type of Clotting Disorder:* _____(dx)	
☐ *Migraines with Aura: If Yes, When?_____(yr)*	
☐ *A Family History of Vein Disease:* _____(dx)	
☐ *A Family History of Leg Ulceration:* _____(dx)	
☐ *A Family History of Blood Clots:* _____(dx)	
☐ *A Family History of a Clotting Disorder:* _____(dx)	
***FEMALE ONLY:* (Please Check Box if Yes)**	
☐ *Are you pregnant or considering a pregnancy sometime in the future?*	
☐ *Are you breast-feeding?*	
☐ *Are your legs more painful associated with menstruation?*	
☐ *Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy?*	
☐ *Frequent Miscarriages? If Yes, How Many?_____*	

Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's Ages:_____

Past Medical History (Please Check All that Apply)
****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

☐ Anemia, Chronic	☐ PFO (patent foramen ovale)	☐ Headaches	☐ Obesity
☐ Anxiety	☐ Depression	☐ Migraines	☐ PBPH
☐ Asthma	☐ Diabetes, Insulin Dependent	☐ Hyperthyroidism	☐ Pelvic Congestion Syndrome
☐ Atrial Fibrillation	☐ Diabetes, Non-Insulin Dependent	☐ Hypothyroidism	☐ Prostate Cancer
☐ Arm Pain	☐ End Stage Renal Disease	☐ Joint Pain	☐ Pregnancy
☐ Arthritis	☐ Emphysema	☐ Kidney Stones	☐ Peripheral Neuropathy
☐ Breast Cancer	☐ COPD – on O2?	☐ Low Back Pain	☐ Radiculopathy
☐ Bronchitis	☐ GERD	☐ Leg Pain	☐ Radiation Therapy

☐ Broken Bones	☐ Hepatitis	☐ Fibromyalgia	☐ Seizures
☐ Easy Bruising	☐ High Blood Pressure/Hypertension	☐ Joint Pain	☐ Stroke
☐ Chronic Pain	☐ HIV/AIDS	☐ Muscle Disease	☐ Ulcer (GI)
☐ Colon Cancer	☐ High Cholesterol	☐ Leukemia	☐ Shingles
☐ Coronary Artery Disease: Angioplasty / Stents?	☐ Heart Failure	☐ Lung Cancer	☐ Peripheral Arterial Disease
	☐ Pacemaker	☐ Lymphoma	☐ Leg Trauma / Surgery
	☐ Heart Attack	☐ Migraine	☐ Blood Clot – DVT / PE
Anti-coagulation?	☐ Irregular Heart Beat	☐ Multiple Myeloma	☐ Ulcer (Wound)
☐ Murmurs	☐ Hyperparathyroidism	☐ Memory Loss	□ Other: _____

How has venous symptoms limited you? (Check mark all that apply)

ACTIVITIES	LIMIT PAIN	ACTIVITIES	LIMIT PAIN
No Limitations	☐	Inability to Attend School	☐
Attending School on a Limited Basis	☐	Inability to Perform Daily Activities (ADL's)	☐
Difficulty Getting up from Chair	☐	Inability to Work	☐
Difficulty Sitting	☐	Requiring Constant Assistance	☐
Difficulty Standing	☐	Requiring Occasional Assistance	☐
Difficulty Walking	☐	Working on a Limited Basis	☐
Difficulty with Daily Activities (ADL's)	☐	Working Light Duty	☐
Difficulty with recreational sports	☐	Other:_____	☐
Functional Limitations	☐	_____	☐

PAST SURGICAL HISTORY
****PLEASE LIST ALL SURGERIES, INCLUDE ALL SPINE SURGERIES****

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES (Please list all allergies or check options, which applies):

□ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
□ No Known Drug Allergies (NKDA)

Allergy Type	Please Describe Allergic Reaction Severity and Symptoms
_____	_____
_____	_____
_____	_____
_____	_____

*Initial:*_____

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MEDICATIONS (Please list all current medications or check options, which applies):

- Complete the information below regarding all medications currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medications, including any herbals or supplements you take.

☐ I brought a copy of my medication list. (*please provide the list to the front desk receptionist*)

☐ Not currently taking any medications.

	BLOOD THINNERS		
☐	Aggrenox/Dipyridamole	☐	Heparin/LMWH
☐	ASA 325mg	☐	Lovenox/Enoxaparin
☐	Brilinta/Tricagrelor	☐	Plavix/Clopidogrel
☐	Cilostazol/Pletal	☐	Pradaxa/Dabigatran
☐	Coumadin/Warfarin	☐	Savaysa/Edoxaban
☐	Effient/Prasugel	☐	Trental/Pentoxifylline
☐	Eliquis/Apixaban	☐	Ticlid/Ticlopidine
☐	Fragmin/Dalteparum	☐	Xarelto/Rivaroxaban
☐	Gingko/Garlic/Vitamin E	☐	Other: _____

Name of Drug, and Supplements	Strength or Dosage	Number of tablets	Total number of tablets per day	Reason for taking medication

PHARMACY NAME	ADDRESS	PHONE & FAX

SOCIAL HISTORY (Please check all that apply):

Smoking	Alcohol Use	Drug Use	Exercise Frequency
☐ Never Smoked	☐ Do no drink alcohol	☐ No History of Drug Use	☐ Never
☐ Quit: Former Smoker	☐ Less than 1 drink a day	☐ Positive History of Drug Use	☐ Once a Day
☐ Smokes Less than Daily	☐ 1-2 drinks a day	☐ IV Drug Use	☐ Few Times a Week
☐ Smokes Daily: # Packs/Day_____	☐ Social Drinker – occasionally per week	☐ If Yes for Option 2 or 3, please detail drugs used:_____	☐ Few Times a Month ☐ Several Times a Day
☐ Other: _____	☐ 3 or more drinks a day	_____	☐ Other: _____

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SOCIAL HISTORY

	MARITAL STATUS		LIVING STATUS		CHILDREN		FRATERNAL		MATERNAL
☐	Married	☐	Lives alone	☐	YES	☐	Alcohol	☐	Alcohol
☐	Single	☐	Lives w/spouse	☐	NO	☐	Drug Use	☐	Drug Use
☐	Divorced	☐	Lives w/family	☐	How many?				
☐	Widow	☐	Other	☐	Boy				
				☐	Girl				

FAMILY HISTORY (Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, PLEASE mark the box under the relationship of the person to you.

CONDITION	**PLEASE MARK YES OR NO**			**RELATIONSHIP OF PERSON TO YOU**				
	YES	**NO**	**Unknown**	**Father**	**Mother**	**Grandparent**	**Brother/Sister**	**Son/Daughter**
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke / TIA	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Depression/ Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐	☐	☐	☐
Venous Insufficiency	☐	☐	☐	☐	☐	☐	☐	☐
Other Conditions: _____	☐	☐	☐	☐	☐	☐	☐	☐

OTHER MEDICAL CONDITIONS* (Check Yes or No for the following)
*Please inform the physician, medical assistant, or front desk staff of any other medical conditions or concerns.

SYMPTOM	**YES**	**NO**	**SYMPTOM**	**YES**	**NO**
Blood Thinners	☐	☐	Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐	Diabetes	☐	☐
Defibrillator	☐	☐	Hepatitis B or C	☐	☐
Premedication Prior to Procedure	☐	☐	HIV / AIDS	☐	☐
Other Biomedical Implant or Hardware	☐	☐	Leg Ulceration	☐	☐
Any Type of Blood Clots	☐	☐	PFO (Patent Foramen Ovale)	☐	☐
Clotting Disorder (or Family History)	☐	☐	Migraines with Aura	☐	☐
Superficial Thrombophlebitis / Vein Disease	☐	☐	Migraines without Aura	☐	☐

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REVIEW OF SYSTEMS (Check Yes or No if you are currently experiencing any of the following)

CONSTITUTIONAL		**YES**	**NO**		**YES**	**NO**
	Fever	☐	☐	Chills	☐	☐
	Weight Loss	☐	☐	Environmental Allergies	☐	☐
	Weight Gain	☐	☐	Dizziness	☐	☐
	Fatigue	☐	☐	Fainting	☐	☐
EYES	Blurred Vision	☐	☐	Double Vision	☐	☐
	Eye Pain	☐	☐	Glaucoma	☐	☐
EARS/NOSE/MOUTH	Hearing Aids?	☐	☐	Loss of Hearing	☐	☐
	Ringing in the Ears	☐	☐	Hoarseness	☐	☐
	Nose Bleeds	☐	☐	Excessive Thirst	☐	☐
CARDIOVASCULAR	Chest Pain	☐	☐	Ankle or Leg Swelling	☐	☐
	Shortness of Breath	☐	☐	Labored Breathing with Exertion	☐	☐
	Palpitations	☐	☐	Pedal Edema	☐	☐
RESPIRATORY	Cough	☐	☐	Pain with Breathing	☐	☐
	Wheezing	☐	☐	Rib Pain	☐	☐
GASTROINTESTINAL	Reflux	☐	☐	Difficulty Swallowing	☐	☐
	Stool - Incontinence	☐	☐	Nausea	☐	☐
	Diarrhea	☐	☐	Vomiting	☐	☐
	Constipation	☐	☐	Heartburn	☐	☐
	Ulcers	☐	☐	Blood in Stool	☐	☐
GENITOURINARY	Urinary Tract Infection	☐	☐	Urinary Retention	☐	☐
	Urinary Hesitancy	☐	☐	Blood in Urine	☐	☐
	Urinary Incontinence	☐	☐	Genital Pain	☐	☐
MUSCULOSKELETAL	Muscle Pain	☐	☐	Joint Swelling	☐	☐
	Joint Pain	☐	☐	Joint Stiffness	☐	☐
INTEGUEMENTARY	Skin Rash	☐	☐	Scarring	☐	☐
	Discoloration	☐	☐	Edema	☐	☐
NEUROLOGICAL	Syncope	☐	☐	Incontinence	☐	☐
	Dizziness	☐	☐	Headaches	☐	☐
	Difficulty Walking	☐	☐	Tremor	☐	☐
	Weakness	☐	☐	Seizure	☐	☐
	Numbness	☐	☐	Memory Loss	☐	☐
	Tingling	☐	☐	Frequent Falls	☐	☐
PSYCHIATRIC	Depression	☐	☐	Anxiety	☐	☐
	Suicidal Thoughts	☐	☐	Hallucinations	☐	☐
ENDOCRINE	Diabetes	☐	☐	Heat Intolerance	☐	☐
	Thyroid Disease	☐	☐	Cold Intolerance	☐	☐
HEMATOLOGY/LYMPHATIC	Bleeding tendencies	☐	☐	Excessive Bleeding	☐	☐
	Immunosuppression	☐	☐	Excessive Bruising	☐	☐
CANCER	_____	☐	☐	_____	☐	☐

*Initial:*_____

Greenwich Health, PLLC
Julie Huang-Lionnet, MD
1472 Post Road, Darien, CT 06820
P: 203.900-3996 or 203.900.3995

Board Certified Anesthesiology
Subspecialty Certification in Interventional Pain Management
Certified in Venous, Regenerative and Cosmetic Medicine
F: 203.900.3998 or 203.902-0166 ▪ www.greenwichhealth.org

PATIENT EDUCATION

Blood Pressure: _____ / _____ **R**_____ _____ / _____ **L**_____

☐ **Hypertension > 140/90 or Pre-Hypertension 120/80 to 139/89**

☐ **Smoking Cessation < 24 Months: Smoking Dangers (tobacco use):**

Smoking and second hand smoke are harmful to your health. If you smoke, STOP! If you are around others who smoke, encourage them to stop. Smoking leads to chronic obstructive pulmonary disease, and increases risk of heart disease, cancer, and stroke. There are many medications and aids available to help you stop smoking. For additional help and/or information, call 1-800-NO-BUTTS (1-800-662-8887) or 1-800-LUNG-USA (1-800-586-4872). (99406)

Staff Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____