

Sclerotherapy Patient Health History Form

Name: _____

Date: _____

Age: _____

Sex: M/F

Directions: Please answer the following questions, trying not to leave any blank spaces. Please circle the appropriate answer.

Past Medical History

1. Have you ever been in the hospital as a patient? Yes No

If yes, for what reason _____

2. Have you ever had surgery? Yes No

If yes, what type of surgery and when? _____

3. Have you ever had vein-stripping surgery? Yes No

If yes, when and which leg? _____

4. Have you ever had vein injections? Yes No

If yes, when, where, and which leg? _____

5. Are you presently under the care of a physician? Yes No

If yes, for what illness or purpose? _____

6. Do you have heart disease? Yes No

lung disease Yes No

high blood pressure Yes No

hepatitis Yes No

arthritis Yes No

leg ulcer Yes No

7. Have you ever had a blood clot? Yes No

If yes, which leg and when? _____

8. Have you ever had phlebitis? Yes No

If yes, which leg and when? _____

Please circle the appropriate answer.

Child Bearing History

- | | | |
|---|-------|----|
| 1. Do you think you are presently pregnant? | Yes | No |
| 2. How many times have you been pregnant? | _____ | |
| 3. Do you intend to have any more children? | Yes | No |
| 4. Are you presently breastfeeding? | Yes | No |

Family

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

- | | | |
|-------------|-----|----|
| Father | Yes | No |
| Mother | Yes | No |
| Brother(s) | Yes | No |
| Sister(s) | Yes | No |
| Other _____ | | |

- | | | |
|--|-----|----|
| 1. Do you experience any of the following? | | |
| a. Aching/pain in your legs' | Yes | No |
| b. Heaviness | Yes | No |
| c. Tiredness/fatigue | Yes | No |
| d. Itching/burning | Yes | No |
| e. Swollen ankles | Yes | No |
| f. Leg cramps | Yes | No |
| g. Restless legs | Yes | No |
| h. Throbbing | Yes | No |
| i. Other _____ | | |
| 2. Have your veins gotten worse in recent months? | Yes | No |
| 3. Do you elevate your legs to relieve discomfort? | Yes | No |
| 4. Do you wear support hose prescribed by a doctor | Yes | No |
| If yes, what type? _____ | | |
| 5. Do you wear light support hose (e.g. sheer energy)? | Yes | No |
| 6. Do they provide relief? | Yes | No |
| 7. Do you have any problem walking? | Yes | No |
| If yes, how does it affect you? _____ | | |
| 8. Do you stand much at work? | Yes | No |
| at home? | Yes | No |
| 9. How does this standing affect your legs? _____ | | |

Please circle the appropriate answer.

10. Do you smoke? Yes No
If yes, how many packs per day? _____
11. Have you ever had your veins evaluated before? Yes No
If so, when and where? _____
12. Have you ever had any test(s) done on your veins? Yes No

Current Medical History

1. Do you have any allergies (medicines, food, pollen, etc.)? If so, please list them and briefly describe your reaction (e.g. rash, hives, shortness of breath, etc.)_ _____

2. Are you allergic to shrimp or shellfish (or any form of Iodine, IVP dye)? Yes No
3. Are you presently taking any medication including prescription and/or non-prescription (over-the-counter) medicines (aspirin, vitamins)? Yes No
If so, list them. _____
4. Do you take any blood-thinning medication? Yes No
5. Are you taking hormones or birth control pills? Yes No
If yes, please list name(s). _____

• Diplomats, American Board of Dermatology • Fellows, American Academy of Dermatology •
• Fellows, American Society for Dermatologic Surgery •
• Fellow, American College of Mohs Micrographic Surgery and Cutaneous Oncology •