



Maryland Laser Skin & Vein Institute, LLC
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Sclerotherapy Patient Health History Form

Name: _____

Date: _____ Age: _____ Sex: M / F

Past Medical History

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

If yes, for what reasons _____

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? _____

"Endovenous laser ablation or Closure?" **Yes** **No**

If yes, when and which leg? _____

4. Have you ever had **vein injections**? **Yes** **No**

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

Laser vein treatment? **Yes** **No**

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, murmur, defect	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? _____

Child Bearing History N/A

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

Blood clotting disorders like bleeding or clotting tendencies or deficiencies?

Venous symptoms:

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 N/A**
4. Do you wear support hose prescribed by a doctor? **Yes No**
If yes, what type? _____

- If yes, have you worn the hose for at least 6 months? **Yes** **No**
- Do they relieve your symptoms? **Yes** **No** **N/A**
5. Do you wear light OTC support hose? **Yes** **No**
6. Do they provide relief? **Yes** **No** **N/A**
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? _____
10. Have you ever had your veins evaluated before? **Yes** **No**
- If so, when and where and results if known _____
- _____
11. Have you ever had any other test(s) done on your veins? **Yes** **No**
- _____

Current Medical History

1. Do you have any allergies ? (medicines, food, pollen) **Yes** **No**
- 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. What prescription medications do you take?
- _____
- _____
4. Do you smoke? **Yes** _____ **No**
5. Do you take any blood-thinning medication? **Yes** _____ **No**
6. Are you taking hormones or birth control pills? **Yes** _____ **No**