

**Patient Questionnaire for Sclerotherapy**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_\_ /\_\_\_\_

Soc Sec # \_\_\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate the date of your last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_

Are you pregnant or planning a pregnancy soon? □ Yes □ No

Are you consulting with Cole Family Practice for: □ Medical reasons □ Cosmetic Only

Have you had prior vein treatment? □ Yes □ No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the prior treatments? □ Surgery □ Injections □ Phlebectomy □ Laser\_\_\_\_\_\_\_\_

Have you ever been treated for the following?

 Leg phlebitis (vein inflammation) □ Yes □ No Hospitalization? □ Yes □ No

 Leg DVT (deep vein blood clot) □ Yes □ No Hospitalization? □ Yes □ No

 Leg ulcer (venous ulceration) □ Yes □ No Hospitalization? □ Yes □ No

 Prior leg fracture or significant trauma □ Yes □ No Hospitalization? □ Yes □ No

 Pulmonary embolism (blood clot in lung) □ Yes □ No Hospitalization? □ Yes □ No

When did your vein problem occur?

 Age \_\_\_\_\_\_\_\_\_\_\_ □ Before pregnancy □ During pregnancy □ After pregnancy

 □ After trauma □ After BCPs or estrogen therapy □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_

What are the ages of your children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you forming new veins? □ Yes □ No Are your present veins getting bigger? □ Yes □ No

Indicate which of the following symptoms you have experienced:

 Thigh / Leg /calf / foot pain? □ Yes □ No For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lower extremity swelling? □ Yes □ No For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lower extremity skin or ulcer problems? □ Yes □ No For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you experience lower extremity pain, is the pain worsened by:

 Extended periods in standing position? □ Yes □ No Heat? □ Yes □ No

 Menstrual periods? □ Yes □ No Exercising and/or walking? □ Yes □ No

If your experience lower extremity pain, is the pain improved by:

 Elevation of the legs? □ Yes □ No Elastic stockings? □ Yes □ No

 Walking and/or exercising? □ Yes □ No

Indicate the type(s) of pain you have experienced in your lower extremities:

 Resting pain? □ Yes □ No Resting cramps? □ Yes □ No Tiredness? □ Yes □ No

 Night cramps? □ Yes □ No Numbness? □ Yes □ No Heaviness in the legs? □ Yes □ No

 Burning sensation? □ Yes □ No Pain in specific areas \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of:

 Varicose vein problems? □ Yes □ No Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phlebitis (vein inflammation? □ Yes □ No Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Deep venous thrombosis? □ Yes □ No Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Venous leg ulcers? □ Yes □ No Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following medical problems:

 Diabetes? □ Yes □ No Hypertension? □ Yes □ No Stroke? □ Yes □ No

 Seizure or convulsions? □ Yes □ No Fainting or dizzy spells? □ Yes □ No

 Blood transfusions? □ Yes □ No Asthma? □ Yes □ No Hives? □ Yes □ No

 Street drug usage? □ Yes □ No Tobacco Smoking? □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_

 Arthritis? □ Yes □ No Septicemia? □ Yes □ No Hepatitis? □ Yes □ No

 Bleeding disorders? □ Yes □ No Heart disease? □ Yes □ No Easy bruising? □ Yes □ No Migraine headaches? □ Yes □ No Autoimmune disease (e.g. lupus)? □ Yes □ No Thrombophlebitis? □ Yes □ No Deep vein thrombosis? □ Yes □ No

 Pulmonary embolus? □ Yes □ No

 Other medical problems? □ Yes □ No (please list) \_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a personal history of allergies to any of the following? (Please list)

 Medication allergies? □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_ Food allergies? □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_

 Latex allergy? □ Yes □ No Adhesive tape allergy or sensitivity? □ Yes □ No

Does your work require a prolonged standing position? □ Yes □ No

Does your work require a prolonged sitting position? □ Yes □ No

Do you wear elastic support stockings? □ Yes □ No Which kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you wear elastic support stockings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate which of the following medications you are taking?

 Aspirin or blood thinners? □ Yes □ No No Anticoagulants? □ Yes □ No

 Birth control or hormones? □ Yes □ No No Chemotherapy? □ Yes □ No

Thyroid medication? □ Yes □ No Prednisone or steroids? □ Yes □ No Insulin? □ Yes □ No Other meds? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_