Patient Questionnaire for Sclerotherapy

Patient Name ______________________________________ Date _____ / ______ /____

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   Anticoagulants □ Yes □ No

Birth control or hormones □ Yes □ No   Chemotherapy □ Yes □ No   Fish Oil □ Yes □ No

Thyroid medication? □ Yes □ No   Prednisone or steroids? □ Yes □ No   Insulin? □ Yes □ No

Other meds? ____