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SCLEROTHERAPY QUESTIONNAIRE

Name:_____Date:_____

Age:_____Sex:_____Height:_____Weight:_____

Referred By:_____

PLEASE ANSWER EACH QUESTION BY CIRCLING YES OR NO

PERSONAL MEDICAL HISTORY (Current complaints)

Are you consulting for:	Cosmetic Purposes	NO	YES
	Medical Reasons	NO	YES
	Both	NO	YES

How many years have you noticed this problem? _____Years

Have you ever been treated for this problem before:		NO	YES
If Yes, by Whom?			
When?			
By What Method?	Injection	NO	YES
	Electrocautery	NO	YES
	Laser	NO	YES
	Surgery	NO	YES

Have you ever been treated for any of the following:

Phlebitis (inflammation of a vein)		NO	YES
	Right Leg	NO	YES
	Left Leg	NO	YES
	Hospitalized?	NO	YES
Leg Ulcer			
	Right Leg	NO	YES
	Left Leg	NO	YES
	Hospitalized?	NO	YES
Pulmonary Embolism (blood clot to lung)		NO	YES
	Hospitalized?	NO	YES

When did your veins occur?

Age:_____		
Before pregnancy	NO	YES
During pregnancy	NO	YES
After trauma	NO	YES
After birth control	NO	YES
After estrogen therapy	NO	YES

Other:_____

Are you developing new veins? NO YES
Are your present veins getting bigger? NO YES

Indicate which of the following problems you have experienced:
Pain in your:

Lower Limbs	RIGHT	LEFT	How Long?_____
Thigh	RIGHT	LEFT	How Long?_____
Calf	RIGHT	LEFT	How Long?_____
Leg	RIGHT	LEFT	How Long?_____
Foot	RIGHT	LEFT	How Long?_____
Swelling of the legs	RIGHT	LEFT	How Long?_____
Skin / ulcer problems	RIGHT	LEFT	How Long?_____
Others			How Long?_____

If you experience pain in your lower limbs:

Is the pain <u>EXACERBATED</u> by:

Extended periods in standing	NO	YES
Position	NO	YES
Heat	NO	YES
Menstrual Periods	NO	YES
Exercising and / or walking	NO	YES
Medication	NO	YES
Other		

Is the pain <u>ALLEVIATED</u> by:

Elevation of limbs	NO	YES
Elastic stockings	NO	YES
Lower of the limbs	NO	YES
Exercising and / or walking	NO	YES
Other		

Indicate the <u>TYPE</u> of pain:

Resting pain	NO	YES
Resting cramps	NO	YES
Night cramps	NO	YES
Tiredness	NO	YES
Heaviness in legs	NO	YES
Pain in specific areas	NO	YES
Numbness	NO	YES
Burning sensation	NO	YES
Other	NO	YES

_____

Additional comments:

_____
_____
_____
_____

Do you have a PERSONAL HISTORY of:

Thrombophlebitis	NO	YES
Pulmonary embolus	NO	YES
Deep vein thrombosis	NO	YES
Septicemia	NO	YES
Lupus	NO	YES
Hepatitis	NO	YES
Bleeding Disorders	NO	YES
Easy bruise ability	NO	YES
Heart Disease	NO	YES
Migraine headaches	NO	YES
Dark spots after:	NO	YES
Pregnancy	NO	YES
Skin injury / surgery	NO	YES
HIV positive (AIDS Test)	NO	YES
Allergies to Medications	NO	YES
Allergies to foods	NO	YES
Allergies to nail polish	NO	YES
Allergies to cosmetics	NO	YES
Allergies or sensitivity to adhesive tape	NO	YES
Proneness to fainting spells	NO	YES
Keloid formation	NO	YES
Other	NO	YES

Do you have a FAMILY HISTORY of:

Varicose vein problems	NO	YES
Phlebitis	NO	YES
Blood Clots	NO	YES
Leg ulcers	NO	YES
Cancer	NO	YES
Other	NO	YES

Does your work require:

Prolonged standing	NO	YES
Prolonged sitting	NO	YES

In the course of a normal day, how much time is spent in a standing position?

10% 20% 30-50% More than 50%

Do you jog, run, jump rope, or do aerobics? NO YES

How often per week?_____

Are you pregnant or planning a pregnancy soon? NO YES

Number of past pregnancies:_____

Do you spend long hours sitting? NO YES

Do you smoke cigarettes? NO YES

Do you wear elastic support stockings? NO YES
What kind?_____

Have you ever had a blood transfusion? NO YES

Are you talking any medication? NO YES

Indicate which of the following:

Aspirin	NO	YES
Anticoagulants	NO	YES
Hormones or contraceptives	NO	YES
Chemotherapy for any type tumor	NO	YES
Thyroid medication	NO	YES
Cortisone	NO	YES
Insulin	NO	YES
Sedatives	NO	YES
Tranquilizers	NO	YES
Appetite depressants	NO	YES
Others		

Indicate the date of your last:

Complete Physical Exam by your primary care physician:_____
Lab tests performed at that time:_____
_____
_____

Is there any additional information that you would consider pertinent?_____
_____
_____
_____
_____