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DERMATOLOGY AND DERMATOLOGIC SURGERY
BOARD CERTIFIED



Sclerotherapy Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____
Age: _____ Height: _____ Weight: _____
Sex: _____ Blood Type: _____ Shoe Size: _____

1. I would like to treat my leg veins for Cosmetic Purposes Medical Reasons Both

How many years have you noticed this problem? _____

Have you ever been treated for this problem? Yes No

If yes, by whom and when? _____

With what method? Injection Electrocautery Laser Surgery

2. Have you been treated for any of the following? Check box if yes, then specify details.

Phlebitis (Inflammation of a vein) Right Leg Left Leg, Date(s): _____

Leg Ulcer Right Leg Left Leg, Date(s): _____

Pulmonary Embolism Date(s): _____

3. At what age did your veins appear? _____

Did they occur:

Before Pregnancy Yes No

After Birth Control Yes No

After Pregnancy Yes No

After Estrogen Therapy Yes No

After Trauma Yes No

Other _____

4. Are you continuing to develop new veins? Yes No

5. Are your present veins getting bigger? Yes No

6. Which of the following have you experienced? Right Leg Left Leg How many years?

Pain in your lower limbs _____

Pain in your thighs _____

Pain in your Calves _____

Pain in your legs _____

Pain in your feet _____

Swelling of the legs _____

Skin or ulcer problems _____

Other, specify _____

7. If you experience pain in your lower limbs, please answer the following questions:

Is the pain exacerbated by any of the following?

- Extended periods of standing Yes No
Menstrual periods Yes No
Heat Yes No
Exercising and/or walking Yes No
Medication Yes No
Other, (if yes, specify) Yes No _____

Is the pain alleviated by any of the following?

- Elevation of the limbs Yes No
Elastic stockings Yes No
Walking and/or exercising Yes No

Indicate the type of pain that you experience:

- Resting pain Yes No Numbness Yes No
Resting cramps Yes No Burning sensation Yes No
Night cramps Yes No Pain in specific areas Yes No
Heaviness in legs Yes No If yes, where: _____
Tiredness Yes No Additional Comments: _____

8. Do you have a family history of:

- Varicose veins Yes No Leg ulcers Yes No
Phlebitis Yes No Cancer Yes No
Blood clots Yes No

9. Check the box if you have a history of any of the following:

- Thrombophlebitis Migraine Headaches Hepatitis
 Pulmonary Embolus HIV positive AIDS test Dark spots after pregnancy,
 Deep Vein Thrombosis Septicemia skin injury, or surgery
 Bleeding Disorders Lupus
 Allergies to medications, foods, nail polish, or cosmetics (list items) _____

 Allergy or sensitivity to adhesive tape or any product containing latex
 Proneness to fainting spells
 Difficult healing or proneness to scarring

10. Does your work require you to be in a prolonged standing or sitting position? Yes No

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

- 10% 20% 30 to 50% More than 50% of the day

12. Do you jog, run, jump rope, do aerobics or a lot of dancing? Yes No

13. Are you pregnant or planning a pregnancy soon? Yes No

14. Do you smoke cigarettes? Yes No

15. Do you wear elastic support stockings? Yes No

16. Have you ever had a blood transfusion Yes No

17. Are you currently taking any medications? Yes No (If yes, list) _____

18. Please indicate the date of your last physical examination: _____