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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 ____

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

8. **Do you have a family history of:**

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

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

- ❑ Thrombophlebitis
- ❑ Pulmonary Embolus
- ❑ Deep Vein Thrombosis
- ❑ Bleeding Disorders
- ❑ Migraine Headaches
- ❑ HIV positive AIDS test
- ❑ Septicemia
- ❑ Lupus
- ❑ Hepatitis
- ❑ Dark spots after pregnancy, skin injury, or surgery
- ❑ 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:** ______________________________