

Name: _____

MR# _____

Date: _____

SCLEROTHERAPY QUESTIONNAIRE

At what age did you notice "spider" veins of your legs? _____

Do you have a problem with spider veins elsewhere on your body? No Yes

If so, where? _____

Do you have varicose veins of your legs? No Yes

Have you ever had treatment for varicose veins or spider veins? No Yes

If so, what? _____

Have your spider veins been getting progressively worse or have they been relatively stable since you first noticed them? _____

Do other family members have a similar problem? No Yes

If so, who? _____

Are your veins more prominent at the time of your menstrual cycle? No Yes

Have you ever taken birth control pills? No Yes

If so, for how long? _____

Are you currently taking birth control pills? No Yes

How many times have you been pregnant? _____

Did the problem get worse after pregnancy? No Yes

Other than pregnancy, have you had wide fluctuations in your weight? No Yes

Do you exercise regularly? No Yes

Have you had problems with swelling of your ankles or legs? No Yes

Do you have pain in your legs? No Yes

Are you allergic to latex? No Yes

Do you have a tendency to bleed or bruise easily? No Yes

Do you smoke? No Yes

Have you ever healed with skin darkening following minor cuts, abrasions, or trauma? No Yes

Are you now suntanned compared with your skin tone during winter months? No Yes

Have you had difficulty with wound healing, abnormal scarring or keloids? No Yes

Female patients: Are you pregnant or planning a pregnancy? No Yes

Are you lactating? No Yes

Do you have or have you had any of the following? (check all that apply)

- | | | | |
|-------------------------------------------------|------------------------------------------------------|----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Blood clot in the leg | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Blood clot in the lung | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Migraines | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Leg pain after walking | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cellulitis |
| <input type="checkbox"/> Leg trauma or surgery | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Leg swelling |

Past and Active Medical Problems: _____

Previous major surgeries and dates: _____

Medications (Please list all prescription and over the counter medications including aspirin, over the counter pain relievers, vitamins and herbals.): _____

Please circle any of the following that you are currently taking or take on an "as needed" basis: aspirin vitamin E ibuprofen Aleve Motrin Midol naprosyn diclofenac Excedrin Coumadin Plavix fish oil ginkgo biloba ginseng garlic Excedrin Alka-Seltzer

Allergies to Medications None Yes (List medication and how you react): _____

Thank you for completing this questionnaire. Please sign: X _____

Reviewed by: _____ Date: _____