

Sclerotherapy Consultation & Medical History

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Age: _____ Email: _____

Phone: Home: _____ Cell: _____ Work: _____

Best number to confirm an appointment? (circle one) Home Cell Work May we leave a message? **Y / N**

Insurance: _____ Occupation: _____ Referred by: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your general health _____

Yes No Have you ever suffered a severe allergic reaction (swollen eyes, asthma, difficulty breathing)?

Yes No Do you have **ANY** allergies or skin sensitivities to medications, foods, Latex or other substances?

Please List _____

Yes No Do you take/use ANY medications, both prescription and non-prescription, herbal or natural supplements, or topical on a regular or daily basis?

Please List _____

Yes No Is there a *family history* of spider and/or varicose veins? _____

Yes No Is there a *family history* of easy bruising, bleeding or clotting disorders, thrombophlebitis?

Yes No Do you have a history of: (please circle all that apply) Thrombophlebitis Septicemia
Hepatitis Slow healing wounds Swelling in the legs/feet/ankels Heart problems Diabetes
Migraine headaches High blood pressure Low blood pressure Other _____

Yes No Any unusual reactions to local anesthetics (Novacaine, Xylocaine)? If **yes**, what reaction occurred: Lightheadedness Fainting Nausea Other _____

Yes No Are you pregnant now?

When did your spider veins occur: (please circle all that apply)

Before pregnancy After pregnancy After an accident (a fall, broken leg, a blow, etc.)

After taking the birth control pill or Premarin At what age did your veins occur? _____

Yes No Have your leg veins ever been treated? If yes, how? (please circle all that apply)

Laser Electrocautery (electric needle) Ligation (stripping, surgery) Injections/sclerotherapy

Date(s) of treatment: _____

Yes No Any complications that followed? _____

Satisfaction, side effects and other results from previous treatments: _____

Yes No Are your veins becoming worse?

Yes No Are you still developing new veins?

Yes No Do you have any of these symptoms in the area(s) to be treated: (please circle all that apply)
Aching, heaviness, tiredness, pain (throbbing, burning, sharp, tingling), itching, cramping

Yes No Does your work require you to be on your feet for long periods of time?

Yes No Do you do any type of exercise that causes violent physical pounding to your legs? (aerobics, running, etc) _____

The above information has been provided to the best of my knowledge.

Patient Signature _____ Date: _____

Reviewed by Dr. Scheel _____ Date: _____