**SCLEROTHERAPY PATIENT INTAKE FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice your enlarged discolored veins? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate in which leg you have the following symptoms:**

|  |  |  |
| --- | --- | --- |
|  | Left Leg | Right Leg |
| Edema (swelling) |  |  |
| Pain location |  |  |
| Tiredness/Heaviness |  |  |
| Ulceration |  |  |
| Skin Color Changes |  |  |
| Spider Veins |  |  |
| Varicose Veins |  |  |
| Spontaneous bleeding from veins |  |  |

1. Please list activities limited by your condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How long have you had venous symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle One

3. Have you had any prior treatment for varicose veins? Yes No

If yes, dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you have history of ulcerations? Yes No

If yes, have they improved over time? Yes No

5. Have you ever had clots in vine of deep vein thrombosis? Yes No

6. Do you wear support hose? Yes No

If yes, are they prescription of over the counter?

If yes, are they knee high or thigh high?

How long have you worn them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have symptoms improved? Yes No

7. Do you take pain medication for your varicose/spider veins? Yes No

If yes, does the medication help? Yes No

8. Do you elevate your legs to relieve your symptoms? Yes No

If yes, does elevating your legs help? Yes No

9. Are your symptoms worse at the end of the day? Yes No

10. What other things do you do to alleviate symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Have you ever gone to the emergency room because of your varicose veins? Yes No

12. Do you have any family history of varicose/spider veins? Yes No

If yes, relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Are you presently employed? Yes No

If yes, what is your position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Do you sit or stand for extended periods of time? Yes No

If yes, how many hours per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Are you currently or have you been on any hormonal therapy or birth control? Yes No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Have you had ANY pregnancies? Yes No

If yes, how many? \_\_\_\_\_\_\_\_\_

17. Do you have or have you had vulvar varicosities? Yes No

18. Do you experience pelvic pain or fullness? Yes No

19. Do you experience migraine headaches? Yes No

20. Have you ever had a reaction to anesthesia? Yes No

21. Do you have a heart defect? Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_