PIMA DERMATOLOGY

ADULT / PEDIATRIC / COSMETIC / LASER & SKIN SURGERY

Sclerotherapy Questionnaire

Patient Full Name (please print): _____ **DOB**: _____ / _____ / _____
(*Month*) (*Day*) (*Year*)

Date: _____

Age: _____ **Male** ☐ **Female** ☐ **Height:** _____ft. _____ in. **Weight:**_____

1. **How many years have you noticed this condition?** _____

2. **Have you ever been treated for your veins?** Yes ☐ No ☐

   If yes, when and by whom? Date: _____ Performed by: _____

   With what method? ☐ Injection ☐ Electrocautery ☐ Laser ☐ Surgery

3. **When did your veins occur?** Age:_____

   If applicable: Before Pregnancy ☐

   After Pregnancy ☐

   After Trauma ☐

   After Birth Control or Estrogen Therapy ☐

4. **Is there a family history of varicose or spider veins?** Yes ☐ No ☐

5. **Do you have a history of:**

	Y	N
Thrombophlebitis	__	__
Pulmonary Embolus	__	__
Deep Vein Thrombosis	__	__
Lupus	__	__
Hepatitis	__	__
Bleeding Disorders	__	__
Easily Bruised	__	__
Heart Disease	__	__
Swollen Feet/Ankles	__	__
Migraines	__	__
Dark Pigmentation After	__	__
Pregnancy, Injuries, Surgery	__	__

Please see reverse side of page.

6. **Do you have any allergies?** If so, please list: _____

_____

	Y	N
7. **Are you developing new veins?**	__	__
8. **Are your present veins getting bigger?**	__	__
9. **After prolonged standing, do your legs ache?**	__	__

10. **If applicable, do your legs or veins ache before or during menstruation?** Y __ N __

	Y	N
11. **Are you required to be on your feet for long periods?**	__	__
12. **Does walking or exercise relieve pain?**	__	__
13. **Does walking or exercise aggravate the pain?**	__	__

14. **What medications do you take? Please list:** _____

_____

	Y	N
15. **If applicable, are you pregnant or planning a pregnancy soon?**	__	__
16. **Do you spend long hours sitting?**	__	__
17. **Do you smoke?**	__	__

Patient Signature: _____

Witness Signature: _____