**New Patient Form: Sclerotherapy**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Directions: Please answer the following questions. Provide estimates for dates of occurrence.**

1. Why are you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you experience any of the following in your legs? **Please Circle**

Aching/pain? Yes No Left Leg Right Leg Both

Heaviness/Tiredness/Fatigue? Yes No Left Leg Right Leg Both

Itching/burning Yes No Left Leg Right Leg Both

Leg swelling? Yes No Left Leg Right Leg Both

Leg pain with walking? Yes No Left Leg Right Leg Both

Leg cramps? Yes No Left Leg Right Leg Both

Foot pain at night? Yes No Left Leg Right Leg Both

Restless legs? Yes No Left Leg Right Leg Both

Throbbing? Yes No Left Leg Right Leg Both

Skin Discoloration? Yes No Left Leg Right Leg Both

Skin/hair changes? Yes No Left Leg Right Leg Both

Ulcer now or in the past? Yes No Left Leg Right Leg Both

Varicose or spider veins? Yes No Left Leg Right Leg Both

1. How long have you had these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have your symptoms gotten **better** or **worse** in the past 6 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How far can you walk before your symptoms begin to bother you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What helps the symptoms improve? **(Please Circle all that apply)**

Leg elevation Tylenol or Ibuprofen Walking

Stopping and resting Compression Stockings Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What makes the symptoms worse: **(Please Circle all that apply)**

Leg elevation Walking Climbing stairs or walking inclines

Stopping and resting Compression Stockings Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are your symptoms **better** or **worse** by the end of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Overall, how much of an impact do your symptoms have on your personal or work life?

**(None)** 0 1 2 3 4 5 **(Severe)**

**Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Have you ever had an ultrasound test done on your legs? Yes No

If yes, when, where, and which leg? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had Sclerotherapy before? Yes No
   * If yes, how did you tolerate it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

1. Current or previous Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Hours you sit or stand during the day: \_\_\_\_\_\_\_\_\_\_\_\_
3. **(WOMEN ONLY)**

Number of pregnancies: \_\_\_\_\_\_\_\_ Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_

1. Exercise per week:

 None  1-5 hours  5-10 hours  more than 10 hours

Type of exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Tobacco use:  Never  Quit If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Current: Cigarettes  Pipe  Cigar  Chew

Amount per day: \_\_\_\_\_\_\_\_\_\_\_\_ Number of years: \_\_\_\_\_

1. Alcohol:  Never  Social  Occasionally  Daily
2. Recreational Drug use:  Never  Social  Occasionally  Daily

**SURGICAL HISTORY:** (Please list any major operations or vein procedures you have had)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICAL HISTORY:** **Height:** \_\_\_\_\_feet \_\_\_\_\_inches **Weight:** \_\_\_\_\_\_\_\_\_\_pounds

(Please list any major medical problems you have such as diabetes, asthma, or high blood pressure.)

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**ALLERGY HISTORY:**  No known allergies

Allergies including medications, dye, iodine, shellfish, latex, and your reaction.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy Reaction Allergy Reaction**

**MEDICATIONS:**  None

Medications including over the counter, herbals and supplements.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_