PATIENT HISTORY AND PHYSICAL

For The Treatment of Sclerotherapy

Name _____ **Date** _____

Address _____ **City/State/Zip** _____

Telephone # (_____)_____ **Work # (_____)**_____

Emergency Contact _____ **Telephone # (_____)**_____

Occupation _____ **Referred by** _____

Date of Birth _____ **Age** ____ **Height** _____ **Weight** _____ **Blood Type** _____ **Shoe size** _____

PERSONAL MEDICAL HISTORY

1. **What is the reason for this consultation?** _____

2. **Are you consulting for cosmetic purposes?** ☐ **Yes** ☐ **No**

3. **How long have you noticed this problem?** _____

4. **Have you ever been treated for this problem?** ☐ **Yes** ☐ **No**

   By whom and when? _____

5. **What method was used?** ☐ Injection ☐ Laser

6. **Have you ever been treated for one of the following?**

   ☐ **Phlebitis** Right leg ____ Left leg ____ Hospitalization ____ When _____

   ☐ **Leg Ulcers** Right leg ____ Left leg ____ Hospitalization ____ When _____

   ☐ **Pulmonary Embolism / Blood clots** Hospitalization ____ When _____

   ☐ **Leg Fracture** Right Leg ____ Left leg ____

7. **When did your veins occur?**

   ☐ Age ☐ Before pregnancy ☐ During pregnancy ☐ After trauma

   ☐ After birth or estrogen therapy ☐ Other

8. **Are you developing new veins?** ☐ **Yes** ☐ **No**

9. **Are your veins getting bigger?** ☐ **Yes** ☐ **No**