YOU'RE SO VEIN AESTHETIC CENTER

SCLEROTHERAPY PATIENT HISTORY AND QUESTIONNAIRE

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Patient Name_____**Date**_____**Age**_____

Adress:_____ **Phone:**_____

Allergies to Medications:_____

Do you have a history of any of the following?	**YES**	**NO**
Diabetes	_____	_____
Heart condition (patent foramen ovale) etc	_____	_____
Migraines	_____	_____
Stroke	_____	_____
Seizures	_____	_____
Lupus or other autoimmune disorder	_____	_____
Infectious illness (HIV, Hepatitis B,C)	_____	_____
Kidney Disease	_____	_____
Asthma	_____	_____
Faints or passes out easily	_____	_____
Do you have a history of the following?		
Blood clots	_____	_____
Leg swelling	_____	_____
Phlebitis	_____	_____
Deep vein thrombosis	_____	_____
Pulmonary Embolism	_____	_____
Are you pregnant or planning to try in the next year?		
Are you taking any of the following medications?		
Aspirin	_____	_____
Blood thinners	_____	_____
Estrogen or progesterone	_____	_____
Birth control pills	_____	_____
NSAIDS (Advil, Naprosyn, Aleve, etc)		
Cortisone, prednisone or topical steroids	_____	_____
Tamoxifen	_____	_____

Other medications_____

Do you smoke?_____

Are you traveling by car or plane in the next week?_____

Please list any other health conditions you have_____

_____

Have you had sclerotherapy in the past?_____