Maryland Laser Skin & Vein Institute, LLC

Robert A. Weiss, MD ● Margaret A. Weiss, MD ● Karen L. Beasley, MD

54 Scott Adam Road ● Suite 301 ● Hunt Valley Maryland 21030

Ph (410) 666-3960 ● Fx (410) 666-3981 ● www.MDLSV.com

Sclerotherapy Patient Health History Form

Name: _____ Date: _____

Age: _____ Sex: M / F

Past Medical History

Name and address of your primary care physician_____

_____

1. Have you ever been in the hospital as a patient? **Yes No**

If yes, for what reasons _____

_____

2. Have you ever had surgery? **Yes No**

If yes, what type of surgery and when? _____

_____

3. Have you ever had **vein-stripping surgery**? **Yes No**

If yes, when and which leg? _____

"Endovenous laser ablation or Closure?" **Yes No**

If yes, when and which leg? _____

4. Have you ever had **vein injections**? **Yes No**

If yes, when, where, and which leg? _____

Laser vein treatment? **Yes No**

5. Are you presently under the care of a physician? **Yes No**

If yes, for what illness or purpose? _____

Maryland Laser Skin & Vein Institute, LLC

Robert A. Weiss, MD ● Margaret A. Weiss, MD ● Karen L. Beasley, MD

54 Scott Adam Road ● Suite 301 ● Hunt Valley Maryland 21030

Ph (410) 666-3960 ● Fx (410) 666-3981 ● www.MDLSV.com

6. Do you have:

heart disease, murmur, defect	**Yes**	**No**
lung disease	**Yes**	**No**
high blood pressure	**Yes**	**No**
hepatitis	**Yes**	**No**
arthritis	**Yes**	**No**
leg ulcer	**Yes**	**No**

7. Have you ever had a blood clot? **Yes No**

If yes, which leg and when? _____

8. Have you ever had phlebitis? **Yes No**

If yes, which leg and when? _____

Child Bearing History N/A

1. Do you think you are presently pregnant? **Yes No**

2. How many times have you been pregnant? _____

3. Do you intend to have any more children? **Yes No**

4. Are you presently breastfeeding? **Yes No**

Name and address of your OB/GYN _____

_____

Family

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

Father Yes No **Mother Yes No**

Brother(s) Yes No **Sister(s) Yes No**

Does anyone in your family have blood clotting disorders like bleeding or clotting tendencies or deficiencies?

_____

Maryland Laser Skin & Vein Institute, LLC

Robert A. Weiss, MD ● Margaret A. Weiss, MD ● Karen L. Beasley, MD

54 Scott Adam Road ● Suite 301 ● Hunt Valley Maryland 21030

Ph (410) 666-3960 ● Fx (410) 666-3981 ● www.MDLSV.com

Venous symptoms:

1. Do you experience any of the following?

   a. Aching/pain in your legs **Yes** **No**

   b. Heaviness **Yes** **No**

   c. Tiredness/fatigue **Yes** **No**

   d. Itching/burning **Yes** **No**

   e. Swollen ankles **Yes** **No**

   f. Leg cramps **Yes** **No**

   g. Restless legs **Yes** **No**

   h. Throbbing **Yes** **No**

   i. Other_____

2. Have your veins gotten worse in recent months? **Yes** **No**

3. Do you elevate your legs to relieve discomfort? **Yes** **No** **N/A**

4. Do you wear support hose prescribed by a doctor? **Yes** **No**

   If yes, what type? _____

   If yes, have you worn the hose for at least 6 months? **Yes** **No**

   Do they relieve your symptoms? **Yes** **No** **N/A**

5. Do you wear light OTC support hose? **Yes** **No**

6. Do they provide relief? **Yes** **No** **N/A**

7. Do you have any problem walking? **Yes** **No**

   If yes, how does it affect you? _____

8. Do you stand much at work? **Yes** **No** at home? **Yes** **No**

Maryland Laser Skin & Vein Institute, LLC

Robert A. Weiss, MD ● Margaret A. Weiss, MD ● Karen L. Beasley, MD

54 Scott Adam Road ● Suite 301 ● Hunt Valley Maryland 21030

Ph (410) 666-3960 ● Fx (410) 666-3981 ● www.MDLSV.com

9. How does this standing affect your legs? _____

10. Have you ever had your veins evaluated before? **Yes** **No**

If so, when and where and results if known _____

_____

11. Have you ever had any other test(s) done on your veins? **Yes** **No**

_____

Current Medical History

1. Do you have any allergies ? (medicines, food, pollen) **Yes** **No**

If so, please list them and briefly describe your reaction:
(e.g. rash, hives, shortness of breath, etc) _____

_____

2. Are you allergic to shrimp or shellfish (or any form of iodine, IVP dye)? **Yes** **No**

3. What prescription medications do you take?

_____

_____

4. Do you smoke? **Yes** **No**

5. Do you take any blood-thinning medication**?** **Yes** **No**

6. Are you taking hormones or birth control pills? **Yes** **No**