Dr. STUART McMASTER

SCLEROTHERAPY PATIENT QUESTIONNAIRE

Date _____
Name _____
D.O.B _____
Who is your regular GP? _____

How did you find out about our vein clinic?

PERSONAL MEDICAL HISTORY – VEINS

How long have your veins been present?

What is your main concern with your leg veins?

Have you had treatment for varicose veins before?
(please circle) **Yes / No**

If yes, by whom and when?

Type of Treatment	Yes	No
Injections	☐	☐
Surgery	☐	☐
Other _____	☐	☐

Have you ever been treated for any of the following?	Yes	No
Phlebitis (inflammation of a vein)	☐	☐
Deep Vein Thrombosis (blood clot in leg)	☐	☐
Pulmonary Embolus (blood clot in lung)	☐	☐
Leg Ulcer	☐	☐

Do you suffer any of the following symptoms from varicose veins?	Yes	No
Leg Pains / Aching	☐	☐
Leg or Ankle Swelling	☐	☐
Varicose Eczema	☐	☐

OTHER MEDICAL HISTORY

Please list all regular medication prescribed by your doctor:

Do you have an implanted cardiac pacemaker?
(please circle) **Yes / No**

Please list any allergies:

Please indicate if you have suffered from any of the following conditions in the past:	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
Seizures	☐	☐
Fainting / Blackouts	☐	☐
Stroke	☐	☐
Autoimmune Disease	☐	☐
Hepatitis / HIV	☐	☐
Bleeding Problems	☐	☐
Toxemia (high blood pressure in pregnancy)	☐	☐
Recurrent Miscarriage	☐	☐
Migrane	☐	☐

Do you have family history of:	Yes	No
Leg Ulcers	☐	☐
Blood Clots	☐	☐

Do you smoke cigarettes?
(please circle) **Yes / No**

If yes, how many per day? _____

Thank you for completing this form.