Aesthetic
SOLUTIONS NY

Aleksandr Benji FNP
115-12 Queens Blvd. Forest Hills, NY 11375
(646) 301-4000

Name: _____ Date of Birth _____

SCLEROTHERAPY PATIENT INTAKE FORM

When did you first notice your enlarged or discolored veins?

_____

Do you have a family history of veins problems? ☐ Yes ☐ No

Please indicate in which leg you have the following symptoms:

	Left Leg	Right Leg
Edema (swelling)		
Pain location		
Tiredness/Heaviness		
Ulceration		
Skin Color Changes		
Spider Veins		
Varicose Veins		
Spontaneous bleeding from veins		

1. Please list activities limited by your condition _____

2. How long have you had venous symptoms? _____

3. Have you had any prior treatment for varicose veins? …… ...Yes ___ No___
   If yes, dates of treatment _____

4. Do you have any history of ulcerations? ……Yes ___ No___
   If yes, have they improved over time? ……...Yes ___ No___

5. Have you ever had clots in veins or deep vein thrombosis? ……Yes ___ No___

6. Do you wear support hose? …….. Yes ___ No___
   If yes, are they prescription ____ or over-the-counter ____?
   If yes, are they knee high ____or thigh high ____?
   How long have you worn them? _____
   Have symptoms improved? ……Yes ___ No___

7. Do you take pain medication for your varicose/spider veins? …….. .Yes ___ No___

If yes, does the medication help? ……Yes ___ No___

8. Do you elevate your legs to relieve your symptoms? ……Yes ___ No___

If yes, does elevating your legs help? ……Yes ___ No___

9. Are your symptoms worse at the end of the day? ……....Yes ___ No___

10. What other things do you do to alleviate symptoms?

_____

11. Have you ever gone to the emergency room because of your varicose veins? …….. Yes ___ No___

12. Do you have any family history of varicose/spider veins? ……..... Yes ___ No___

If yes, relationship to you _____

13. Are you presently employed? ……..... Yes ___ No___

.

If yes, what is your position? _____

14. Do you sit or stand for long periods of time? ……..... Yes ___ No___

If yes, how many hours per day? _____

15. Are you currently or have you been on any hormone therapy or birth control pills? … Yes ___ No___

If yes, please list _____

16. Have you had ANY pregnancies? ……..... Yes ___ No___

If yes how many? _____

Did symptoms worsen after pregnancy? ……...Yes ___ No___

ARE YOU CURRENTLY PREGNANT? ……Yes ___ No___

Are you currently nursing/breast feeding? ……Yes ___ No___

17. Do you have or have you had vulvar varicosities? ……...Yes ___ No___

18. Do you experience pelvic pain or fullness? ……...Yes ___ No___

19. Do you experience migraine headaches? ……Yes ___ No___

20. Have you ever had a reaction to anesthesia? ……Yes ___ No___

21. Do you have a heart defect? ……...Yes ___ No___

If yes, please describe_____

Patient Signature: _____ Date: _____

Patient Name (Print): _____

*Be Advised: All Packages Must Be Used Within 6 Months of the Date of Purchase. Initial Here_____