

CLIENT QUESTIONNAIRE

Sclerotherapy

MEDICAL INFORMATION:

NO YES

- ____ ____ Allergies
- ____ ____ Aspirin, Ibuprofen; If yes, when? _____
- ____ ____ Auto-immune disease, HIV, Lupus, Hepatitis
- ____ ____ Currently taking Birth Control Pills or other Hormones
- ____ ____ Bruise easily, Cuts
- ____ ____ Diabetes
- ____ ____ Eczema
- ____ ____ Irregular, Pigmented Moles or Growths
- ____ ____ Keloids, Pigmented Scars
- ____ ____ Currently Pregnant or Breast Feeding?
- ____ ____ Alcohol; If yes, when? _____
- ____ ____ Any condition not listed: _____
- ____ ____ Currently under the care of a physician?
- ____ ____ Currently taking any medication? _____
- ____ ____ Previous leg vein treatment;
If yes, when? _____ Agent used, if know; _____

AREA TO BE TREATED: _____