WILSON AESTHETICS PATIENT INFORMATION SHEET

NAME:____

MAILING ADDRESS:_______________________________________

PHONE:_______________________ DATE OF BIRTH:_______________

EMERGENCY CONTACT NAME & PHONE #:_________________________

PLEASE LIST ANY MEDICATIONS/VITAMINS WHICH YOU ARE TAKING:

_______________________ _______________________

_______________________ _______________________

_______________________ _______________________

_______________________ _______________________

ALLERGIES:____

____

INFORMED CONSENT FOR TREATMENT

I understand that by signing this form, I authorize the nurse to treat my spider veins with sclerotherapy/BBL. The side effects involved with this are: ALLERGIC REACTION, SUPERFICIAL CLOT, PHLEBITIS, INFECTION, BLEEDING, ULCER FORMATION, BRUISING, SKIN DISCOLORATION, BURN, BLISTER, SCARRING, FAILURE TO ACHIEVE RESULTS.

I also realize that the average person needs 3-6 treatments to each spider vein in order to get the best results and that it is important to wear prescription quality compression hose to obtain the best results.

We do not file treatments with any insurance companies. Payment in full must be made at the time of service.

I have read and understand this agreement and all of my questions have been answered to my satisfaction. I agree to the terms of this agreement.

....

PATIENT SIGNATURE:_______________________________________

DATE:_____________________

WITNESS

WILSON INTERVENTIONAL CLINIC, P.A.

Medical History Form

Patient Name______________________________ Date of Birth__________________

Dear Patient:
We need to know your medical history in order to provide the best possible care. Please take a few minutes to answer all questions. Add any information that you believe Dr. Wilson should know about your health. Feel free to ask for help with this form if necessary. Thank You.

Age__________ Height__________ Weight__________
Who referred you to our office?____

Why are you seeing Dr. Wilson today?_____________________________________

Past Medical History
Do you see a doctor regularly for any medical reasons? YES NO
If yes, what doctor and for what problem?__________________________________

____

Please check any of the following problems that you have:

_CANCER	_HEART DISEASE	_DIABETES	_STROKE	_COLITIS	_ULCERS
_EPILEPSY	_KIDNEY DISEASE	_LEUKEMIA	_HEPATITIS	_HIV	_AIDS
_JAUNDICE	_PNEUMONIA	_CATARACTS	_GLAUCOMA	_ANEMIA	_LUNG DISEASE
_HEADACHES	_NERVOUS BREAKDOWN		_HIGH BLOOD PRESSURE		

_OTHER____

Have you had any serious injuries? YES NO
If yes, please list date(s) and type of injury:______________________________

____

Have you had any surgeries? YES NO
If yes please list dates and type of surgery:________________________________

____

____

***Please list any medications and/or supplements that you take and how much you take:**

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do you have any allergies to medications prescribed or over the counter? YES NO
If yes please list the medication and the reaction that you had (example: Tylenol-itching):_______

____

Family History
Please fill in if the following family member has had a major illness/disease. If the family member has died, please list their age and cause of death.
Mother____
Father____
Brother____
Sister____

For patients being seen for varicose veins or spider veins:

Have you had treatment for varicose veins/spider veins in the past? YES NO

What did you have done?____

Have you had any sores/ulcers on your legs? YES NO

Have you had any blood clots? YES NO

Are you currently taking hormone therapy/birth control pills? YES NO

If yes, what medication?____

Have you had any pregnancies? YES NO

If yes, how many pregnancies?____

Do you wear or have ever worn compression hose? YES NO

Are they/were they over the counter or prescription? OTC RX

Did they seem to help with your symptoms? YES NO

Are you currently employed? YES NO

If yes, what type of job do you have?____

Do you sit or stand for long periods of time? YES NO

If yes, how many hours per day?____

Do you take any medication for the spider/varicose veins? YES NO

If yes, please list:____

Does putting your legs up help relieve your symptoms? YES NO

Please circle the leg of the symptoms listed below that you have:

Edema	Right leg	Left leg
Pain	Right leg	Left leg
Tiredness	Right leg	Left leg
Sores/ulcers	Right leg	Left leg
Color changes	Right leg	Left leg
Spider veins	Right leg	Left leg
Varicose veins	Right leg	Left leg

Informed consent for
SCLEROTHERAPY INJECTION TREATMENT

Please read carefully before signing.

I have been fully informed concerning the sclerotherapy procedure. I understand the treatment to be for the purpose of elimination of spider veins.

I further understand that most medical procedures involve the element of risk. **Side effects of this treatment may include, but are not limited to: allergic reactions, blood clot, temporary phlebitis, infection, bleeding, failure to eliminate veins, ulcer formation, pigment staining of the skin, bruising, even death.** These effects have been fully explained to me.

I understand that the average patient requires 3-5 treatments to each spider vein in order to get complete clearance, and that I may not fall into this range, possibly needing more or less treatments.

I understand that payment for each sclerotherapy treatment is required at the time of service. This is not a service which will be filed with my insurance company.

I hereby acknowledge that this information has been given to me, and that all of my questions have been satisfactorily answered. I authorize the Wilson Interventional Clinic physician or staff, to perform the above-described procedure, which is necessary to treat my condition. My consent is valid for whatever time frame necessary until further notice.

Patient:______________________________ Date:______________

Witness:______________________________ Date:______________

WILSON INTERVENTIONAL CLINIC
628 Hospital Drive, Suite 3D
Mountain Home, AR 72653
Phone: 870-425-3737

Instructions to help you after your Sclerotherapy treatment:

1. Leave your hose on for 24 hours. Remove the bandages and then you may take a shower.
2. Wear the pantyhose, while you are awake, for 1 week after the treatment. You can not wear your hose too much
3. The veins will look worse before they look better.
4. There will be bruising which is normal.
5. Occasionally there is a hard knot that may be tender. This is normal; it is trapped blood, which we can drain easily for you.
6. Occasionally there is a brownish discoloration after injections. This is temporary and will fade over time. It can take several months to fade.
7. Occasionally there will be tenderness and minor swelling in the area treated. Extra strength Tylenol will help with this discomfort. Wearing your hose helps with this also.
8. Occasionally there will be minor itching after a treatment. Benadryl cream or tablets should help with this. If this is severe or if you begin to have breathing problems, take a Benadryl and go to the nearest emergency department.
9. **We advise against:** shaving for 2 days after each treatment, running or heavy aerobics for 1 week, sitting in hot tubs or swimming for 1 week, and tanning for 1 week after your treatment.

Thank you for choosing Wilson Interventional Clinic.

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