

SURNAME: _____ NAME: _____ Birthdate: _____

Dear patient!

To help You in the best possible way, we kindly ask You to answer the following questions.

Do You have any pre-existing illnesses? (e.g. high blood pressure, arrhythmia, diabetes)

NO YES (please list them below)

Do You assume medication regularly?

Did You have any chirurgical surgery regarding the affected limbs?

NO YES (please write the date of the surgery below)

Are You taking any painkillers?

NO YES (which ones?)

Do You have allergies?

NO YES: _____

Do You assume blood thinners?

NO YES

What is Your profession? _____

Which sports do You practice? _____