SURNAME: _____ **NAME:** _____ Birthdate: _____

Dear patient!

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

Trauma

_____
_____
_____

Where did it happen?

_____

When did it happen?

_____

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? _____