	Yes	No
12. Do you have a family history of:		
Varicose vein problems Which family member _____	☐	☐
Phlebitis Which family member _____	☐	☐
Blood clots Which family member _____	☐	☐
Leg ulcers Which family member _____	☐	☐
Cancer Which family member _____	☐	☐

	Yes	No
13. Do you have a history of:		
Diabetes	☐	☐
High blood pressure	☐	☐
Seizures or convulsions	☐	☐
Fainting or dizzy spells	☐	☐
Stroke	☐	☐
Blood transfusions	☐	☐
Asthma	☐	☐
Hives	☐	☐
Arthritis	☐	☐
Thrombophlebitis	☐	☐
Pulmonary embolus	☐	☐
Deep vein thrombosis	☐	☐
Septicemia	☐	☐
Autoimmune disease (i.e. Lupus)	☐	☐
Hepatitis	☐	☐
Bleeding disorders	☐	☐
Easy bruisability	☐	☐
Heart disease	☐	☐
Migraine headaches	☐	☐
Dark spots after pregnancy, skin injury or surgery	☐	☐
HIV positive (AIDS test)	☐	☐

14. Do you have a personal history of allergies to medications? (Please list)

_____

15. Allergies to any foods? ☐ **Yes** ☐ **No**