16. **Allergies to nail polish?** ☐ Yes ☐ No

17. **Allergies to cosmetics?** ☐ Yes ☐ No

18. **Allergies or sensitivity to adhesive tape?** ☐ Yes ☐ No

19. **Does your work require a:**

Prolonged standing position ☐ Yes ☐ No

Prolonged sitting position ☐ Yes ☐ No

20. **In the course of a normal day, how much time is spent in a standing position?**

☐ 10% of the day ☐ 20% of the day ☐ 30% to 50% of the day ☐ More than 50%

21. **Does walking or exercise relieve or aggravate the pain?** ☐ Yes ☐ No

22. **Do you jog, run, jump rope or aerobics?** ☐ Yes ☐ No

How often per week? _____

23. **Are you pregnant or planning pregnancy soon?** ☐ Yes ☐ No

24. **Number of past pregnancies and year of births** _____

25. **Do you spend long hours sitting?** ☐ Yes ☐ No

26. **Do you smoke cigarettes?** ☐ Yes ☐ No

If yes, how many packs per day? _____

27. **Do you wear elastic support stockings?** ☐ Yes ☐ No

What kind? _____ **How often?** _____

28. **Have you ever had a blood transfusion?** ☐ Yes ☐ No

	Yes	No
29. **Are you taking any medication?**	☐	☐
Indicate which of the following you are taking:		
Aspirin	☐	☐
Anticoagulants	☐	☐
Hormones or contraceptives (birth control pills)	☐	☐
Chemotherapy for any type of tumor	☐	☐
Thyroid medication	☐	☐
Cortisone	☐	☐
Insulin	☐	☐
Sedatives (sleeping pills)	☐	☐
Tranquilizers	☐	☐
Appetite suppressants	☐	☐

Others - please specify _____