Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check off YES or NO if you have or had in the past any of the below:

1. Diabetic Lesions YES \_\_\_\_\_ NO \_\_\_\_\_

2. Fractures YES \_\_\_\_\_ NO \_\_\_\_\_

3. History of Blood Clots YES \_\_\_\_\_ NO \_\_\_\_\_

4. Tumors YES \_\_\_\_\_ NO \_\_\_\_\_

5. Infectious Disease YES \_\_\_\_\_ NO \_\_\_\_\_

6. Skin Conditions YES \_\_\_\_\_ NO \_\_\_\_\_

7. Pregnant (1st 3 Months) YES \_\_\_\_\_ NO \_\_\_\_\_

8. Fever/Illness YES \_\_\_\_\_ NO \_\_\_\_\_

9. Cirrhosis of Liver YES \_\_\_\_\_ NO \_\_\_\_\_

10. Hypertension (Meds) YES \_\_\_\_\_ NO \_\_\_\_\_

11. Any Failing Organs YES \_\_\_\_\_ NO \_\_\_\_\_