Blood Flow Restriction Rehabilitation Questionnaire

Patient Name:

Date:

Do you now, in the past, or have a family history of the following conditions? Please check				If Yes, please indicate self or family history	
Condition	**Yes**	**No**		**Self**	**Family History**
Blood Clots/Deep Vein Thrombosis					
Abnormal Clotting Times					
Vascular Disease or Compromise					
Cardiopulmonary Conditions					
Atherosclerosis					
Renal Compromise					
Acidosis					
Extremity Infection					
Tumor in the Affected Extremity					
Increased Intracranial Pressure					
Hypertension					
Diabetes					
Sickle Cell Trait					
General Infection					

Are you currently taking:	**Yes**	**No**
Blood pressure medication		
Medications and Supplements Known to Increase Clotting Risk		
Creatine supplements		

The information above is correct to the best of my knowledge.

x _____

Patient/Parent/Guardian Signature Date