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## Screening Questionnaire for Blood Flow Restriction

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1. Do you have a history of high blood pressure?  Yes  No
2. Do you have diabetes?  Yes  No
3. Do you have a history of deep-vein thrombosis (DVT), hereditary thrombotic tendency or antiphospholipid antibody syndrome?  Yes  No
4. Are you currently pregnant?  Yes  No
5. Do you have a history of varicose vein of legs?  Yes  No
6. Do you have a history of prolonged immobility?  Yes  No
7. Do you have a history of atrial fibrillation or heart failure?  Yes  No
8. Do you have a personal or family history of clotting disorders (e.g. Lupus, hemophilia, high platelets, etc.)?  Yes  No
9. Do you have a history of pulmonary embolus?  Yes  No
10. Do you have a history of injury to your arteries or veins?  Yes  No
11. Do you have a history of injury to any of your nerves  Yes  No
12. Does your current or previous training include resistance training?  Yes  No

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_