Compression Therapy Questionnaire

Please complete the following questionnaire and return it to your physician.

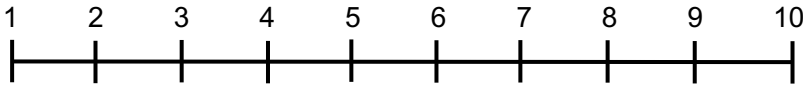
Upper Limbs

1. Did you feel pressure in your fingertips?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

2. Did you experience any pain in your hands?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

3. Did you experience any itchiness in your hands?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

4. How difficult was the compression therapy for your hands?
   Please rate on a scale from 1 to 10:
   1 = Not difficult at all
   10 = Extremely difficult / unbearable



5. Please write any comments or suggestions regarding hand compression therapy.
   (Examples: It was uncomfortable, hard to wear, etc.)

   _____

   _____

Lower Limbs

6. Did you feel pressure in your toes?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

7. Did you feel pressure in your ankles?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

8. Did you feel pressure in your calves?
   ☐ Yes ☐ Slightly ☐ Almost none ☐ None

9. Did you experience any pain in your feet or legs?

☐ Yes ☐ Slightly ☐ Almost none ☐ None

10. Did you experience any itchiness in your feet or legs?

☐ Yes ☐ Slightly ☐ Almost none ☐ None

11. How was the process of wearing and removing the compression stockings?

☐ Very easy

☐ Manageable

☐ Difficult, but I could do it myself

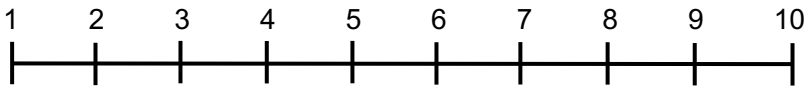
☐ I needed assistance

12. How difficult was the compression therapy for your feet and legs?

Please rate on a scale from 1 to 10:

1 = Not difficult at all

10 = Extremely difficult / unbearable



13. Please write any comments or suggestions regarding foot/leg compression therapy.

(Examples: It was uncomfortable, hard to wear, etc.)

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_____

Thank you for your cooperation.