**Patient Diary**

**Please indicate at what stage you were able to return to work and your normal daily activities (the activities you were able to do prior to treatment).**

**Please also indicate the day when you stopped wearing the compression stockings (if provided).**

**(Please tick one box)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Day I was able to resume my normal activities** | **Day I returned to work** | **Day I stopped wearing compression stockings (if provided)** |
| **Day of surgery** |  |  |  |
| **Day after surgery** |  |  |  |
| **2 days after surgery** |  |  |  |
| **3 days after surgery** |  |  |  |
| **4 days after surgery** |  |  |  |
| **5 days after surgery** |  |  |  |
| **6 days after surgery** |  |  |  |
| **7 days after surgery** |  |  |  |
| **8 days after surgery** |  |  |  |
| **9 days after surgery** |  |  |  |
| **10 days after surgery** |  |  |  |
| **>10 days after surgery** |  |  |  |

Please return to:

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