Peripheral Vascular Health Questionnaire

Name:______________________________ pt #:__________
Date: / /

(Please circle yes or no)

Question		
Do you smoke or have you ever smoked?	Yes	No
Do you have high blood pressure or are you on blood pressure medication?	Yes	No
Do you have high cholesterol or are you on medication to lower your cholesterol?	Yes	No
Have you ever been told that you have had a heart attack or stroke?	Yes	No
Have you ever had an angioplasty or stent placed in the heart or leg?	Yes	No
Have you noticed your walking pace has slowed?	Yes	No
Have you ever been told you have Diabetes? Even borderline Diabetes?	Yes	No
Do your legs ever feel tired causing you to stop and rest?	Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?	Yes	No
Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet when lying down that improves when you stand up?	Yes	No
Do you have any infections or sores that are not healing on your feet or toes?	Yes	No
Is the skin on your legs or feet pale, reddish or purple?	Yes	No
Is the skin on your legs or feet cool to the touch?	Yes	No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	Yes	No
Have you ever had any testing done to your legs for these diseases?	Yes	No
Do you have numbness and tingling in your arms, legs or feet?	Yes	No
Do you have decreased or no hair growth on your toes, feet or lower legs?	Yes	No
Do you have a family history of diabetes or heart problems?	Yes	No

Office Use:

Diminished pulses: L R B
Pulselessness: L R B

Pad net test for: pain ulcer pre-op poor pulses other:__________