

PAD Assessment (Peripheral Artery Disease)

TODAY'S DATE _____

FIRST NAME _____

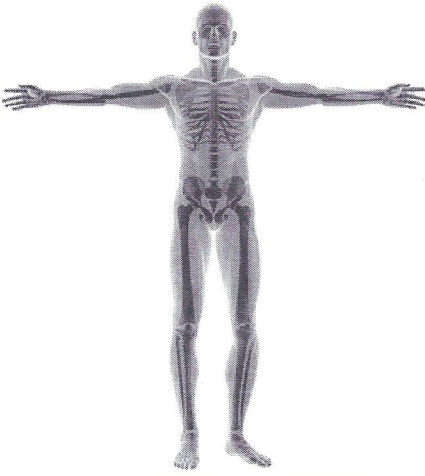
LAST NAME _____

DATE OF BIRTH _____

Peripheral Artery Disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build-up of plaque.

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

Circle YES or NO on the following questions and check all boxes that apply:

<p>1 Have you ever been diagnosed with Peripheral Vascular Disease or been diagnosed as having poor circulation?</p> <p style="text-align: right;">YES NO</p>	<p>6 If you have pain, does the pain subside with rest?</p> <p style="text-align: right;">YES NO</p>
<p>2 Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs, or arms? If yes, dates: _____</p> <p style="text-align: right;">YES NO</p>	<p>7 Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed?</p> <p style="text-align: right;">YES NO</p>
<p>3 When you walk, do you experience aching, cramping or pain in your legs, thighs, or buttocks?</p> <p style="text-align: right;">YES NO</p>	<p>8 Do you have any painful sores or ulcers on legs or feet that do not heal?</p> <p style="text-align: right;">YES NO</p>
<p>4 If you answered Yes to #3, when do you feel the pain:</p> <p><input type="checkbox"/> After walking 1 block</p> <p><input type="checkbox"/> Climbing a flight of stairs</p> <p><input type="checkbox"/> After walking 100 yards</p> <p><input type="checkbox"/> Walking at increased speed</p>	<p>9 Are your legs discolored or bluish?</p> <p style="text-align: right;">YES NO</p>
<p>5 If you answered Yes to #3, circle the area(s) of the body on the diagram below where you feel pain.</p> 	<p>10 Check all that apply:</p> <p><input type="checkbox"/> I am a current smoker</p> <p><input type="checkbox"/> I have a history of smoking</p>
	<p><input type="checkbox"/> I have diabetes</p> <p><input type="checkbox"/> I have a family history of diabetes</p>
	<p><input type="checkbox"/> I have high cholesterol</p> <p><input type="checkbox"/> I have a family history of high cholesterol</p>
	<p><input type="checkbox"/> I have high blood pressure/hypertension</p> <p><input type="checkbox"/> I have a family history of high blood pressure/hypertension</p> <p><input type="checkbox"/> I have coronary artery disease (CAD)</p> <p><input type="checkbox"/> I have a family history of coronary artery disease</p> <p><input type="checkbox"/> I have had a stroke/mini-stroke/TIA</p> <p><input type="checkbox"/> I have a family history of stroke/mini-stroke/TIA</p>