

Today's Date: _____



PAD ASSESSMENT
(Peripheral Artery Disease)

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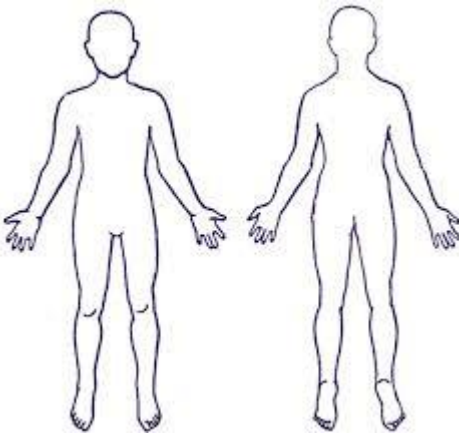
First Name

Last Name

D.O.B.

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 plaque build-up. Please fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

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