Capital District Podiatry, PLLC

Peripheral Arterial Disease Vascular Questionnaire

Name:_____

Date: _____

***Risk Factors/Symptoms* :**

1. Do you smoke**:**	Yes/No
2. Are you being treated for High Blood Pressure	Yes/No
3. Are you being treated for High Cholesterol	Yes/No
4. Have you ever had a Stroke or TIA	Yes/No
5. Have you had Vascular Surgery	Yes/No
6. Do you have Diabetes	Yes/No
7. Do your feet experience numbness, tingling, burning	Yes/No
8. Do your feet or legs experience pain at night or with rest	Yes/No
9. Does Exercise or Walking cause pain in your legs/feet	Yes/No
10. Do you have a Sore or Ulcer on your Foot or leg(s)	Yes/No
11. Are your Feet Cold	Yes/No
12. Do you have any history of Heart Disease	Yes/No