Patient Name: ________________________ Date of Birth: _____________ Today's Date: _____________

Patient questionnaire for Arterial and Nerve Disease

We would appreciate you filling out the following form. Answers to these questions will assist us in determining if you are at risk for Peripheral Artery Disease (PAD) or Peripheral Neuropathy. These medical issues can be further assessed utilizing our in-office state-of-the-art testing.

Please mark "Yes" or "No"

		Yes	No
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue tingling, cramping or pain) when you walk, which is relieved by rest?		
2.	Do you experience any pain in your lower leg(s) or feet, while resting?		
3.	Have you noticed less hair growth below your knees?		
4.	Are your toes or feet pale, discolored or bluish?		
5.	Have you experienced pain, burning or tingling in your arms and legs?		
6.	Are you experiencing lack of feeling in your legs or feet?		
7.	Are you or have you suffered from upper or lower back pain recently?		
8.	Do you find it hard to tell how hot or cold water is when you step into the tub/shower?		
9.	Do you suffer from leg pain mostly at night?		
10.	Do you have a high cholesterol level or other blood lipid problems, or take medication to lower cholesterol levels?		
11.	Do you have high blood pressure or take medication for high blood pressure?		
12.	Do you have, or have you had, an infection, skin wound or ulcer on your feet/toes that was very slow to heal (8-10 weeks)?		
13.	Have you ever smoked?		
14.	Have you previously had a stroke?		
15.	Do you suffer from a heart disease?		

Thank you,

Nurse signature: ____ Date: ______________

Physician signature: ____ Date: _______________