Advanced Radiology Services PC

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Vascular Disease Questionnaire

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Do you have any sores or ulcers on your legs or feet that are not healing: ☐ Yes ☐ No

Do you have chronic swelling on your legs or feet: ☐ Yes ☐ No

Do you have diabetes: ☐ Yes ☐ No
If yes, what type: _____
If yes, what treatment are you following: _____

Do you have high blood pressure: ☐ Yes ☐ No

Do you use tobacco: ☐ Yes ☐ No
If yes, what types: ☐ Smoke cigarettes ☐ Chewing tobacco ☐ Other (e.g. environmental exposure)
If yes, how often: _____ Have you quit: ☐ Yes ☐ No Date: _____

Do you drink alcohol or use illegal drugs: ☐ Yes ☐ No
If yes, how often: _____ Have you quit: ☐ Yes ☐ No

Have you ever had high cholesterol: ☐ Yes ☐ No
If yes, what medications do you take: _____

Have you ever had a stroke or TLA (mini-stroke): ☐ Yes ☐ No

When you walk do you experience cramping in your: Thighs ☐ Yes ☐ No
Legs ☐ Yes ☐ No
Buttocks ☐ Yes ☐ No
If yes, does it go away with rest: ☐ Yes ■ No

How far can you walk without discomfort: _____

Do you have numbness or tingling in your: Legs ☐ Yes ☐ No
Feet ☐ Yes ☐ No
If yes, have you ever had any testing or previous procedures for this : ☐ Yes ☐ No

If yes, what have you had done: _____