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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: _____