

## 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 |

