

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys, become narrowed or clogged. It affects over 12 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficulty controlling blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Last Name _____ First Name _____ Date of Birth _____

Primary physician _____

Please CIRCLE 'Yes' or 'No' and indicate which leg	Yes or No		Which Leg?		
1. Do you experience discomfort, fatigue, aching, tingling, cramping, or pain in your feet, calves, thighs, or buttocks when you walk or exercise?	Yes	No	Left	Right	Both
2. If you answered yes to #1, does the pain go away with rest?	Yes	No	Left	Right	Both
3. Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	Left	Right	Both
4. Do you ever require assistance to walk (i.e., cane, walker, motorized cart, someone's arm)? If so, please explain: _____	Yes	No	Left	Right	Both
5. Have you been diagnosed with diminished or absent pedal (foot) pulses?	Yes	No	Left	Right	Both
6. Have you ever been diagnosed with arthritis, nerve damage, disk herniation, or a disease related to your bones and/or spine?	Yes	No	Left	Right	Both
7. Have you had any procedure to treat any blood vessels?	Yes	No	Left	Right	Both
8. Are you experiencing any of the following on your legs, feet, toes, below the knee? <i>Please check all that apply.</i>					
_____ Pale, discolored, or bluish	_____ Hair loss or uneven distribution over time				
_____ Dry or atrophic or shiny skin	_____ Dystrophy brittle nails				
_____ Ulcers, sores, slow healing wounds (8-12 weeks)	_____ Infection that may be gangrenous (black skin)				
9. Risk Factors (please check all that applies and specify when indicated.)					
_____ Smoking History/Date quit _____ / ____ / ____	_____ High Cholesterol				
_____ Diabetes	_____ Previous Stroke/ TIA				
_____ Coronary Artery Disease	_____ Hypertension				
_____ Chronic Kidney Disease, stage: _____	_____ Previous Obstructive Vascular Disease				
_____ Congestive Heart Failure	_____ Age >50				
Patient Signature _____	Date _____				

Additional Notes: _____

