About Your Peripheral Vascular Health

Name:_______________________________   Date:__________

Circle “Yes” or “No”*:  

1. Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise?   Yes  No

2. If you answered “yes” to question number 1, Does the pain go away with rest?   Yes  No

3. Do you have numbness and tingling in your arm(s) or leg(s) or feet?   Yes  No

4. Are your fingers or toes pale, discolored, or bluish?   Yes  No

5. Are your hands or feet cold to the touch?   Yes  No

6. Do you have open sores or ulcers on your leg(s) or feet that won’t heal?   Yes  No

7. Do you exercise on a regular basis?  
If no, what keeps you from exercising? _________________  

8. Do you have a family history of diabetes or cardiovascular problems (immediate family: parent, sister, brother)?   Yes  No

9. Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms, or kidneys?   Yes  No

*Answers to these questions will determine if a vascular screening exam like the one pictured above will help us better assess your health status.