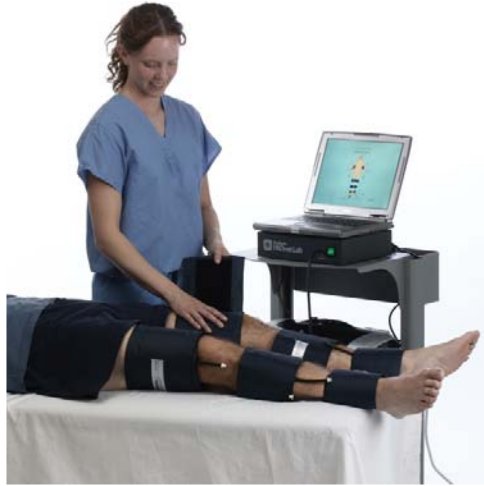

About Your Peripheral Vascular Health

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? Yes No
   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.***