CENTRIC HEALTH
A MULTISPECIALTY GROUP PRACTICE

Patient Screening Form

www.PVDprogram.com

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PERIPHERAL VASCULAR DISEASE PROGRAM

Name:_____Date of Birth:_____

Address:_____ Phone Number: _____

(Please circle your answers to the questionnaire)

Do you smoke or have you ever smoked?	Yes	No
Do you have high blood pressure or are you on blood pressure medication?	Yes	No
Do you have high cholesterol or are you on medication to lower your cholesterol?	Yes	No
Have you ever been told that you have had a heart attack or stroke?	Yes	No
Have you ever had an angioplasty or stent placed in the heart or leg?	Yes	No
Have you noticed your walking pace has slowed?	Yes	No
Have you ever been told you have diabetes? Even borderline diabetes?	Yes	No
Do your legs ever feel tired causing you to stop and rest?	Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?	Yes	No
Do you ever experience cramping, tightness, “charlie horses” or pain in the legs or feet when lying down that improves when you stand up?	Yes	No
Do you have any infections or sores that are not healing on your feet or toes?	Yes	No
Is the skin on your legs or feet pale, reddish or purple?	Yes	No
Is the skin on your legs or feet cool to the touch?	Yes	No
Do you have frequent abdominal or back pain?	Yes	No
Do you have a family history of abdominal aortic aneurysm disease?	Yes	No

Additional comments?

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