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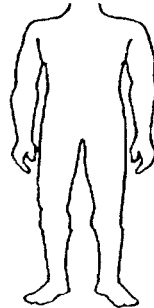
## Patient Questionnaire Are you at risk for Peripheral Arterial Disease?

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Circle **Yes** or **No** to the following questions:

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks which is relieved by rest? **Yes** **No**

2. If applicable, circle the area of the body on the diagram below where you feel pain:



3. Do you have any painful sores or ulcers on your legs or feet that aren't healing? **Yes** **No**

4. Do you have Diabetes or take medication for Diabetes? **Yes** **No**

5. Have you had surgery, balloon procedures, or stents to any blood vessels other than your heart? **Yes** **No**

6. Have you had blockages in your coronary arteries? **Yes** **No**

7. Do you have Carotid Artery Disease? **Yes** **No**

8. Do you Smoke or have you smoked in the past?  
For how long? **Yes** **No**