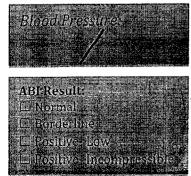
## SCREENING FOR PERIPHERAL VASCULAR DISEASE (PVD)

Name: Mr. / Ms. PCP: Dr.	Date of Birth:
***************************************	nether you qualify for PVD screening, please complete this page. Thank you!
A. Symptoms:	: Please check any that apply to you.
☐ Yes ☐ No	Pain or cramping in the hip, thigh or calf muscle after any activity such as walking or climbing stairs. If Yes, please check: $\Box$ Left side $\Box$ Right side $\Box$ Both
☐ Yes ☐ No	Pain or cramping in the hip, thigh or calf muscle when resting-sitting or lying down. If Yes, please check:   Left side  Right side  Both
☐ Yes ☐No	Temperature difference between the legs, i.e. one is cooler than the other
☐ Yes ☐ No	Weakness or numbness in legs/feet. If Yes, please check:   Left side  Right side  Both
☐ Yes ☐ No	Sores or open wounds in your feet or lower legs that are slow to heal.
$\square$ Yes $\square$ No	Color changes in your feet such as a purple or blue color.
☐ Yes ☐No	Hair loss or slow hair growth on the skin of your legs.
☐ Yes ☐ No	Varicose veins or spider veins.
☐ Yes ☐ No	Shiny or darkened appearance to the skin of your legs.
☐ Yes ☐ No	Aching, burning or swelling of legs and/or feet.
☐ Yes ☐ No	Restless legs syndrome while at rest.
☐ Yes ☐ No	MEN: erectile dysfunction; WOMEN: pelvic pain
B. History: Pl	lease check any that apply to you.
$\square$ Yes $\square$ No	Do you have diabetes? ☐ Yes ☐No Are you on dialysis?
☐ Yes ☐ No	Have you had any previous vascular procedures? TypeYear
☐ Yes ☐ No	Have you ever smoked? # of years:
☐ Yes ☐ No	Over 50 years old with high cholesterol, high blood pressure or heart disease?
$\square$ Yes $\square$ No	Diagnosis or family history of heart disease?
☐ Yes ☐ No	Do you have a family history of vascular disease, i.e. varicose veins/spider veins
For Office Use:	





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