PATIENT NAME (LAST, FIRST): _____ **DOB (mm/dd/yyyy):** _____

Review of Symptoms: Arterial

1. Do you experience pain in the buttocks, hips, thighs and/or legs while walking? If so, please indicate the pain score (out of 10).
   - o Yes- If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): _____ /10
   - o No

2. Do you experience pain in the buttocks, hips, thighs and/or legs while resting and/or at nighttime when laying down? If so, please indicate the pain score (out of 10).
   - o Yes - If yes, please describe the pain/sensation and rate it out of 10 (0 being no pain, 10 being the worst pain): _____ /10
   - o No

3. How long (in minutes) can you walk before experiencing pain?

   _____

4. How far (in approximate feet) can you walk before experiencing pain?

   _____

5. Do you experience numbness in your legs, feet or toes?
   - o Yes
   - o No

6. Do you experience tingling sensations (pins and needles) in your legs, feet or toes?
   - o Yes
   - o No

7. Do you experience sensations of coolness in your legs, feet or toes?
   - o Yes
   - o No

8. Do you experience weakness in your legs, feet or toes?
   - o Yes
   - o No

9. Do you have any current open wounds/ulcers on the legs, feet or toes? When was the onset?
   - o   Yes - When did this first occur? _____
   - o   No

10. Do you have a history of slow to heal wounds/ulcers on the legs, feet or toes?
    - o   Yes
    - o   No

11. Are you currently taking any cholesterol medication? If so, please indicate the name of the medication.
    - o   Yes - Name of medication: _____
    - o   No

12. Are you currently taking any blood thinners (Xarelto, Eliquis, Warfarin, Aspirin, etc.)? If so, please indicate the name of the medication.
    - o   Yes - Name of medication: _____
    - o   No

13. What was your most recent A1C?

    _____

14. Have you been previously diagnosed with arterial disease?
    - o   Yes
    - o   No

15. Have you ever been treated for arterial disease? If so, please indicate the name of the procedure(s).
    - o   Yes, Name of procedure(s): _____
    - o   No

16. Do you have any upcoming travel?
    - o   If yes, where? _____

    Method of Travel (car, bus, train, plane) _____
    - o   No

17. Do you have any upcoming procedures?
    - o   Yes - Name of procedure(s): _____
    - o   No