MIDWEST VASCULAR
& VARICOSE VEIN CENTER

Patient Name: _____ Date of Birth: _____

Patient Phone #: _____ Referral From:_____

PAD Patient Questionnaire

(Please complete and return to front desk before you see the doctor)

****** Do you currently smoke or have a history of smoking?**	**Yes**	**No**
****** Do you have type I or type II diabetes?**	**Yes**	**No**
****** Do you take blood pressure medication to control high blood pressure or high cholesterol?**	**Yes**	**No**
****** Do you take cholesterol medication to control high cholesterol?**	**Yes**	**No**
Have you ever had a heart attack or stroke?	Yes	No
Have you ever had an angioplasty or stent placed in the heart or leg?	Yes	No
Do you ever have to **stop walking** because you have pain or cramping in your buttocks, thighs, or calves? Does it go away after a short rest?	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

Free Screening Criteria: Must be 55 years of age or older AND meet one or more of the first 4 listed medical conditions (items with an asterisk)