Personal Information:

Name: _____ Date of Birth: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip Code: _____

Phone Number: (h): _____ (c) : _____ Social Security Number: _____

Email: _____

Race: _____ Ethnicity: _____ Primary Care Doctor: _____

Occupation: _____ Are You Retired? : Yes / No

Do you have a living will? : Yes / No Does your Insurance Require a Referral? Yes / No

Allergies: □ No Known Allergies □ Drug/Food/Environmental: _____

Medications:

Medications	Dosage	Medication	Dosage

Preferred Pharmacy:

Name of Pharmacy: _____
Pharmacy Location (Street, City, State: _____
Pharmacy Phone Number: If known) : _____

Review Of Systems: Please check all that apply

□ Numbness in hands/feet	□ Difficulty swallowing	□ Cough	□ Nose bleeds
□ Difficulty hearing	□ Swelling in feet/ankles	□ Coughing up blood	□ Vomiting
□ Double vision	□ Excessive thirst	□ Night sweats	□ Diarrhea

□ Abdominal pain	□ Swelling in legs	□ Skin rash	□ Constipation
□ Leg pain when walking	□ Frequent urination	□ Trouble sleeping	□ Mood swings
□ Bloody bowel	□ Black bowels	□ Weight loss	□Ffever
□ Painful urination	□ Chills	□ Other	

Personal Medical History: □ No Known Problems

□ Anemia	□ COPD	□ High Blood Pressure	□ Peripheral Artery Disease
□ Anxiety/Depression	□ Diabetes	□ HIV/AIDS	□ Renal Disease
□ Arrhythmia	□ Diverticulitis	□ Hypertension	□ Seasonal allergies
□ Arthritis	□ Headache/migraines	□ Hypothyroidism	□ Seizure/epilepsy
□ Asthma	□ Heart attack	□ hyperlipidemia	□ Sexual dysfunction
□ Blood clots/ DVT	□ Heart murmur	□ Leg pain	□ STD
□ CHF	□ Heart palpitations	□ Mental Illness	□ Stroke/ TIA
□ Chronic pain	□ Heart Stent	□ Numbness in Extremities	□ Swelling of Extremities
□ Claudication	□ Heart Surgery	□ Pacemaker	□ Other

Procedure & Surgeries: □ None

Procedure	Date (s)	Procedure	Date (s)

Family History: (check all that apply) □ Unknown □ Unable to obtain □ Adopted

Type	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Alcoholism	□	□	□	□	□	□	□	□
Anemia	□	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□

Type	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Heart Disease	□	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□	□	□
Other								

Social History:

Alcohol □ Current □ Past □ Never

□ Beer □ Wine □ Liquor

Tobacco Use: □ Current □ Past □ Never

□ Cigarettes □ Cigar □ Oral □ Pipe □ Vape

Drug Use: □ Current □ Past □ Never

Please list if any: _____

Exercise & Physical Activity: □ Never □ 1-2 times / week

□ 3-4 times / week □ 5-5 times / week □ Other

PAD Assessment (Peripheral Artery Disease) Today's Date: _____

Peripheral Artery Disease is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a build up of plaque.

Fill out this questionnaire so your physician can evaluate whether or not you may be at risk of have symptoms of PAD.

Circle YES or NO on the following Questions and check all boxes that apply.

1. Have you ever been diagnosed with Peripheral Artery Disease or been diagnosed as having poor circulation.

   YES or NO

2. Have you ever had surgery, balloon procedures or stents in your heart, kidneys, belly, legs or arms?

   YES or NO

If yes, dates: _____

3. When you walk, do you experience aching, cramping, or pain in your legs, this or buttocks?

   YES or NO

4. If you answered YES to #3, when do you feel the pain:

   □ after walking 1 block
   □ climbing a flight of stairs
   □ after walking 100 yards
   □ walking at increased speed

5. If you answered YES to #3, circle the area(s) of the body of the diagram below where you feel the pain.

6. If you have pain, does the pain subside with rest?

   YES / NO

7. Do your feet or toes bother you most nights while lying in bed?

   YES / NO

   If yes, do you feel relief when you dangle your feet at the edge of the bed?

   YES / NO

8. Do you have painful sores or ulcers on your legs or feet that do not heal?

   YES / NO

9. Are your legs discolored or bluish?

   YES / NO

10. Check all that apply:
    □ I am a current smoker
    □ I have a history of smoking
    □ I have diabetes
    □ I have family history of diabetes
    □ I have high cholesterol
    □ I have family history or high cholesterol
    □ I have high blood pressure (HTN)
    □ I have family history of high blood pressure
    □ I have/had coronary artery disease (CAD) / heart attack
    □ I have family history of coronary artery disease (CAD / heart attack
    □ I have had a stoke/ mini stroke / TIA
    □ I have family history of stroke / mini stoke / TIA