

HEART & VEIN CENTER, P.A.

PVD/PAD Screening Form

Name _____ DOB _____ Date _____

If you have lower extremity pain, please describe:

Location (buttocks, thighs, knees, feet): _____

Timing (Continuous, occasional, episodic): _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Comments

- | | | |
|---|----------------|----------------|
| 1. Leg cramping? | Y / N | _____ |
| 2. Numb/cold/pale feet? | Y / N | _____ |
| 3. Pain when leg is elevated and improves when leg is dangled? | Y / N | _____ |
| 4. Symptoms relieved with rest and start during exercise? | Y / N | _____ |
| 5. Decreased ability to walk for any reason? | Y / N | _____ |
| 6. Leg heaviness/tiredness/fatigue? | Y / N | _____ |
| 7. Itching/burning/red/hot/swollen/throbbing legs? | Y / N | _____ |
| 8. Have your veins gotten worse in recent months? | Y / N | _____ |
| 9. Have you ever had a blood clot in your legs or phlebitis? | Y / N | _____ |
| 10. Do you use any type of compression/support hose?
Do they provide relief? | Y / N
Y / N | _____ |
| 11. Are you taking any pain medicine?
What type and how often? | Y / N | _____
_____ |
| 12. Are you taking any iron supplements or Vitamins with iron? | Y / N | _____ |
| 13. Have you ever had your veins evaluated before?
Where and when? | Y / N | _____
_____ |
| 14. Painful/nonbleeding ulcers on feet or toes? | Y / N | _____ |