Peripheral Vascular Questionnaire

Name:_____ Date:_____

Please circle **Yes** or **No** to the following questions:

1.	Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise?	Yes No
2.	If you answered "**yes**" to question number 1, Does the pain go away with rest?	Yes No
3.	Do you have numbness and tingling in your arm(s) or leg(s) or feet?	Yes No
4.	Are your fingers or toes pale, discolored, or bluish?	Yes No
5.	Are your hands or feet cold to the touch?	Yes No
6.	Do you have open sores or ulcers on your leg(s) or feet that won't heal?	Yes No
7.	Do you exercise on a regular basis? If no, what keeps you from exercising? _____	Yes No
8.	Do you have a family history of diabetes or cardiovascular problems (immediate family: parent, sister, brother)?	Yes No
9.	Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms, or kidneys?	Yes No