Patient Name:_____ Date of Birth:_____

BAY VASCULAR SURGERY

Dear Patient,

We want to make you aware of a condition that may affect you. As many as 18 million Americans have **(PAD) Peripheral Arterial Disease** and many go dangerously unrecognized. It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed or clogged due to the buildup of plaque. This is the same disease process that causes blockage in the heart. **Poor circulation** may result in the legs when the blood flow becomes sluggish or even blocked. It can result in leg pain or fatigue, which can limit your physical activity. Having PAD may also increase your risk of a heart attack or stroke if untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk or would like more information, please do not hesitate to ask.

1. Do you have foot, calf, buttock, hip, or thigh discomfort (aching, fatigue, tingling, cramping, or pain) when you walk, that Is relieved by rest? ☐ YES ☐ NO

   If YES, does the pain away within 10 minutes of stopping? ☐ YES ☐ NO
2. Do your legs ever feel fatigued or heavy when walking or are active?

   ☐ YES ☐ NO
3. Are you bothered most nights with burning, pain or coldness in your feet or toes?

   ☐ YES ☐ NO
4. Are your toes or feet pale, discolored, or bluish?

   ☐ YES ☐ NO
5. Do you ever need to stop and rest when walking or have difficulty keeping up with others?

   ☐ YES ☐ NO
6. Would you have difficulty doing any of the following because of leg fatigue, weakness, or discomfort...

   Walking one block? ☐ YES ☐ NO

   Climbing one flight of stairs? ☐ YES ☐ NO

   Walking at an increased pace? ☐ YES ☐ NO
7. Have you noticed any changes in the color or temperature of your feet?

   ☐ YES ☐ NO

   Or experienced poor healing of wounds?

   ☐ YES ☐ NO
8. Do you have history of, or take medication for any of the following...

   ☐ Diabetes or "Borderline" diabetes ☐ Stroke

   ☐ Age >70 years ☐ Hypertension

   ☐ Smoking history ☐ Heart Disease

Physician Use Only

Physician Signature: _____ Date: _____

Notes:_____

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