

Cary L. Copeland D P M Inc.  
Cary L. Copeland, D.P.M.  
Dominic A. Rizzo, D.P.M.  
Renee L. Ash, D.P.M.

4260 Glendale-Milford Road Ste 103  
Cincinnati, OH 45242

Mt. Airy Medical Bldg. #1  
4250 Kipling Avenue Ste 209  
Cincinnati, OH 45239

(513) 769-4408  
fax: 769-4578

### Peripheral Vascular Questionnaire

(For Doctor's Only)

Name: \_\_\_\_\_  
Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

Patient to be tested? YES NO

#### SYMPTOMS

1. Do you have pain in your legs? \_\_\_\_\_ Yes No  
If Yes, is the pain in the right, left, or both leg? (Circle One)
2. Do you experience leg discomfort with exercise? \_\_\_\_\_ Yes No
3. Does the discomfort ease when you stop walking? \_\_\_\_\_ Yes No
4. Does the discomfort occur at approximately the same distance every time you walk? Yes No
5. Do you experience leg discomfort at rest? \_\_\_\_\_ Yes No  
If Yes, is the pain in the right, left, or both legs? (Circle One)
6. Do you have a non-healing sore on your foot or leg? \_\_\_\_\_ Yes No  
If yes, is it on the right, left, or both legs? (Circle One)
7. Do you have discoloration of your foot or toes? \_\_\_\_\_ Yes No  
If Yes, is it on the right, left, or both legs? (Circle One)

#### Risk Factors

1. Do you have high blood pressure? \_\_\_\_\_ Yes No  
How many medications do you take for it? 1 2 3+
2. Do you currently smoke? \_\_\_\_\_ Yes No  
How many packs/day 1 2 3+  
Have you smoked within the past 10 years? Yes No
3. Do you have diabetes? \_\_\_\_\_ Yes No  
Do you take insulin? Yes No  
Was it Juvenile onset? Yes No
4. Do you have high cholesterol? \_\_\_\_\_ Yes No  
Do you take any medication for it? Yes No