



PERIPHERAL ARTERIAL DISEASE SCREENING AND ASSESSMENT

Date _____

Name _____ Doctor _____

- 1) Do you get any discomfort, aching or fatigue in your leg(s) when you walk?
- 2) Do you have discomfort or difficulty if you walk up an incline or go up stairs?
- 3) If yes, does the discomfort disappear when you stop walking?
- 4) Does the discomfort ever begin when you are standing still or sitting?
- 5) Do you ever need to stop and rest when you are walking? Why?
- 6) How much walking do you do on a typical day?
- 7) Do you ever use assistance to walk (i.e. a cane, walker, motorized cart or someone's arm)?
- 8) Do you have numbness in your feet?
- 9) Have you given things up you once enjoyed to do over the last year due to leg fatigue, weakness or discomfort?

To be filled out by Doctor or Medical Personnel

None Indicated

Angiogram

ABI R ___ L ___ Date _____

Segmental ABI Date _____ Intervention

3 Month ABI R ___ L ___ Date _____

6 Month ABI R ___ L ___ Date _____

12 Month ABI R ___ L ___ Date _____

RISK FACTOR ASSESSMENT

- 1) Smoking History / Date Quit _____
- 2) Diabetes
- 3) Coronary Artery Disease
- 4) High Cholesterol
- 5) Previous Stroke/ TIA
- 6) Hypertension
- 7) Previous PAD
- 8) Age > 50
- 9) Obesity BMI > 30

PHYSICAL EXAM

- | | | |
|--|------------------------------|-----------------------------|
| 1) Skin cool to touch | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2) Absence of hair or uneven distribution | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3) Presence of dry, atrophic skin | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4) Presence of skin discoloration | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5) Dystrophic brittle nails | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6) Muscle weakness or atrophy | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7) Wounds or ulcers present on lower extremities | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8) Rubor when dependent & pallor with 45 degree elevation 30 seconds | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9) DP and PT pulses present | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

** Specify abnormalities on Left or Right

NOTES: