

Patient Name: _____ DOB: _____

Vascular Patient Questionnaire

LSG005

Do you get leg pain? Yes No If yes, how often do you get this pain?

Describe the type of pain.

What part of your leg? (Circle all that apply)

<i>Buttock</i>	Right or Left	<i>Foot</i>	Right or Left
<i>Thigh</i>	Right or Left	<i>Toes</i>	Right or Left
<i>Calf</i>	Right or Left		

When do you get pain? (Check one)

- Standing
- Walking Upstairs
- Walking Downstairs

How far can you walk at a fast pace? Number of Blocks _____

What do you do for the pain? (Check all that apply)

- Stop & Rest How long do you rest? _____
- Sit down & rest How long do you rest? _____
- Legs Elevated
- Legs Down
- Exercise
- Compression Stockings
If so for what duration have you tried them # _____ weeks or # _____ months
- Take Medication (Write the name of all medications used to control pain.)
Over-the-Counter: _____
Prescription: _____

Do you currently work? Yes or No

If yes, does your pain interfere with your work? Yes or No

Explain: _____

Describe any previous vascular surgery or studies you have had: (Did you bring the original films/reports with you?)

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Medical Assistant Initials: _____