

# Do I Need a Test for PAD?

*Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Circle "Yes" or "No":

### Test for PAD

- |    |   |     |    |                          |                 |
|----|---|-----|----|--------------------------|-----------------|
| 1. | Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? | Yes | No | <input type="checkbox"/> | (440.21)        |
| 2. | Do you experience any pain at rest in your lower leg(s) or feet?  | Yes | No | <input type="checkbox"/> | (440.22)        |
| 3. | Do you experience foot or toe pain that often disturbs your sleep?  | Yes | No | <input type="checkbox"/> | (440.22)        |
| 4. | Are your toes or feet pale, discolored, or bluish?  | Yes | No | <input type="checkbox"/> | (444.22)        |
| 5. | Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?  | Yes | No | <input type="checkbox"/> | (707.10-707.19) |
| 6. | Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?   | Yes | No | <input type="checkbox"/> | (443.9)         |
| 7. | Have you suffered a severe injury to the leg(s) or feet?  | Yes | No | <input type="checkbox"/> | (904.8)         |
| 8. | Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?  | Yes | No | <input type="checkbox"/> | (440.24)        |

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date : \_\_\_\_\_