PAD Risk Assessment Form

NAME ____ Date _____________________________

ADDRESS ____

CITY, STATE, ZIP ____

PHONE ___________________________________ EMAIL ___________________________________

Birth date: ____/___/____ **Current Age:**________ **Gender: (circle)** Male Female

Race: (Circle) Caucasian African American Hispanic Asian/Pacific Islander

Hispanic/Latino Native American Other:_________________

Circle "Yes" or "No":

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, how long can you walk before the pain starts? ___________

Do you experience any pain at rest in your lower leg(s) or feet?………………………………………… Yes No

Do you experience foot or toe pain that often disturbs your sleep?……………………………………… Yes No

Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? ………. Yes No

Has a health care provider ever told you that you have diminished or absent pedal (foot) pulses?……. Yes No

Are you less than 50 years old, with diabetes and one other atherosclerosis risk factor (smoking, abnormal cholesterol, high blood pressure) (PLEASE CIRCLE)……………………… Yes No

Are you aged 50 to 69 years and have diabetes? ………………………………………………………. Yes No

Are you aged 50 – 69 years and have a history of smoking (current or former smoker)?………………Yes No

Are you 70 years or older?……………………………………………………………………………… Yes No

Brachial Pressures:	Right __________	Left_________	
Ankle Pressures:	Right _________ (☐ PT - ☐ DP)	Left_________ (☐ PT - ☐ DP)	
ABI:	Right__________	Left _________	
Right Results are:	☐ Abnormal	☐ Inconclusive	☐ Normal
Left Results are:	☐ Abnormal	☐ Inconclusive	☐ Normal
Discuss with your doctor:	☐ At your next scheduled visit	☐ ________________________________	

Release: In consideration of my participation in this program, I understand and agree to the following: The information provided on this form is, to the best of my knowledge, complete and correct. Participation in this program is voluntary and may include taking a personal and family medical history, blood pressure measurements, use of Doppler ultrasound instruments, listening to blood flow, or for carotid bruits, pulse rate check, referring me to my doctor or other provider of medical care and follow-up consultation. A low risk assessment is not a guarantee of good health and participation in this program cannot substitute for consultation with a physician or other medical professional for any medical or health-related condition, or for regular physical examinations. I hereby release and agree to hold harmless, the site that is conducting or participating in this program, the Vascular Disease Foundation and any sponsors; their officers, directors, employees, agents, volunteers, and representatives from any claims, liability or damages, including but not limited to personal injury or illness, arising in any way from my participation in this program. All medical information obtained through my participation in this program will be kept confidential and will be used by the Vascular Disease Foundation and any sponsors above only for data collection and reporting in aggregate format.

SIGNATURE: ____ DATE: _______________