VASCULAR/NEUROPATHY WORK SHEET

Do you experience pain at rest in your lower legs or feet?			YES	NO
Do you experience pain in your legs/feet when walking?			YES	NO
If yes, where does it hurt when walking?	THIGHS	KNEES	CALVES	FEET
Is the pain in your legs and/or feet relieved by rest?			YES	NO
How long does it take for the pain to subside after rest?			___________	
Are your toes or feet pale, discolored, or bluish?			YES	NO
Do cuts on your arms/hands and/or legs/feet take a long time to heal?			YES	NO
Have you noticed that less hair grows below your knees than above them?			YES	NO
Do you have or have you had ulcers on your feet?			YES	NO
Have you noticed that your feet feel cold even when the temperature is warm?			YES	NO
Do you suffer from numbness, tingling, burning, or pain in your legs and/or feet?			YES	NO
Do you have a high cholesterol level of other blood lipid problem, or do you take medication to lower cholesterol?			YES	NO
Do you have high blood pressure or take mediation for high blood pressure?			YES	NO
Do you have diabetes?			YES	NO
Have you ever smoked?			YES	NO
Have you previously had a stroke?			YES	NO
Do you have heart disease?			YES	NO

over please

CONSENT for RELEASE of INFORMATION & MEDICAL RECORDS

Date:__________

Patient's name:____

SSN:__________-________-_______________ Date of Birth:_____/_____/_____

I hereby give my permission for:____
hospital/physician/insurance company

Address:____
Street City State
Zip

Work phone:____________________________________ Work fax:____

To release or disclose to:____
hospital/physician/insurance company

Address:____
Street City State
Zip

Work phone:____________________________________ Work fax:____

The following information:____

For the period beginning:_________________________________ and ending:_________________________________

This information will be used for:____

I authorize this information to be released. This consent is subject to revocation at any time by me in writing.

Signature of patient:____ Date:_______________________________

Signature of parent (If minor):____ Date:_______________________________