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:_____