CARDIOVASCULAR ASSOCIATES OF AMERICA

Sample Self Assessment Tool for Vascular Patients

PAD/PVD SCREENING TOOL

1.	Do you experience any pain in your legs or feet while at rest?	Yes No
2.	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hips, or thighs during walking/exercise?	Yes No
2(b).	If yes to Question 2, does the pain go away when you stop walking/exercising?	Yes No
3.	Do your feet get pale, discolored, or bluish at any time during the day?	Yes No
4.	Do you have an infection, skin wound, or ulcer on your legs or feet that has been slow to heal over the past 8-12 weeks?	Yes No
5.	Are you over the age of 50?	Yes No
5(b).	Are you over the age of 65?	Yes No
6.	Do you have high cholesterol or other blood lipid (fat) problems, or do you require cholesterol medication?	Yes No
7.	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
8.	Do you have diabetes?	Yes No
9.	Do you have a history of chronic kidney disease?	Yes No
10.	Do you currently or have you ever smoked?	Yes No
11.	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
12.	Do you have a history of heart disease or heart attack?	Yes No
13.	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No

Contact Us for More Information

matt@strategyco.com • kaitlin.scholz@strategyco.com • brown@cvausa.com