ART VASCULAR

Arterial · Revascularization · Therapies

NEW / RETURNING PATIENT **F/U: 3 MONTH 6 MONTH 9 MONTH 1 YEAR**

PATIENT ID: _____ PHONE: _____ DOS: _____

PATIENT NAME: _____ DOB: _____ AGE: _____

HEIGHT: _____ FT _____ IN CURRENT WEIGHT: _____ LBS

Do you experience:

Heaviness _____Tired legs _____ Cramps _____ Tingling _____ Burning _____ Numbness _____

Dry, discolored skin _____ Hair loss _____ Cold feet _____ Swelling _____

Block claudication 1 2 3 _____ Pain level (1-10) _____ Onset of pain: _____

Which side is Worse? **RIGHT / LEFT / BOTH** Pain radiates from back/hips to toes: _____

Pain gets better with rest: _____ Rest pain? _____ **WHEELCHAIR / CANE / WALKER / NONE**

Varicose veins _____ Compression Stockings _____ Do they help? **YES / NO**

Foot or toe pain disturbs your sleep? _____ What do you do to make it better? _____

Pain gets worse when: _____

Describe your pain/symptoms:_____

Medication: _____ Does med help? _____

Do you have skin wounds or ulcers on your feet or toes? YES / NO

Specify location: _____ How long? _____

Have you ever had vascular surgery on your leg(s)? YES / NO

Date/Location: _____ Did it help? **YES / NO**

Procedure Type: _____

Are the symptoms worse? _____

Describe: _____

Allergic to Medications / CONTRAST: NKDA / NO _____

Smoking History: **Never** Yes, how many a day? _____ Quit: _____

_____ **Diabetes** _____ **Hypertension** _____ **High Cholesterol** _____ **Congestive Heart failure**

_____ **Gangrene** _____ **Chronic Kidney Disease** _____ **Dialysis, what days?** M / T / W / T / F / S / S

_____ **Coronary Artery Disease** _____ **Previous Stroke / TIA** _____ **Other:** _____

Have you had the COVID VACCINE? **YES / NO** _____

Have you had any labs (within the last 30 days)? **YES / NO** _____

Surgical History: _____

Patient Signature: _____ Date: _____