

OCEAN STATE CARDIOVASCULAR & VEIN CENTER
Lower Extremity Questionnaire

Today you are scheduled to have a lower extremity/limited exercise tolerance test. This test will help your doctor determine the presence and/or severity of several types of peripheral vascular disease. Please answer the following important questions to help us perform the best test possible. **Please check all that apply.**

Name _____ Date _____

Date of Birth _____ Primary Care Physician: _____

Vascular Surgeon: _____ Cardiologist: _____

1. Have you ever had chest pains, pressure, tightness or angina? No _____ Yes _____
 - a) How often? Rarely ___ Weekly ___ Daily
 - b) Does it occur at rest? No _____ Yes _____
 - c) What types of activities bring it on? _____
2. Do you get short of breath with exercise? No _____ Yes _____
3. Have you ever had a heart attack? No _____ Yes _____
4. Have you ever had an angioplasty, a stent, open heart? No _____ Yes _____
5. Have you ever had a stent put in your legs, or have vascular surgery? No _____ Yes _____
6. Do you smoke or have you ever smoked? No _____ Yes _____
 - a) How many packs per day and for how long? _____
 - b) How many years since you last smoked? _____
7. Do you have diabetes? No _____ Yes _____
8. Do you have high blood pressure? No _____ Yes _____
9. Do you have high cholesterol? No _____ Yes _____
10. Do you have leg pain? No _____ Yes _____
 - a) How far can you walk before pain starts? _____
 - b) Do you have leg pain at rest? No _____ Yes _____
12. Do you exercise regularly? No _____ Yes _____
13. Do you have any allergies to any medications? No _____ Yes _____
14. What medicines do you currently take?

