LEG PAIN, COULD IT BE REAL?

Patient Name: _____

Contact Number: _____

1.) Are you over the age of 50 and have high blood pressure, diabetes or ever smoked? Do you have prior Peripheral arterial disease or Coronary artery disease?
YES or NO (Please circle one)

2.) Are you over the age of 65?
YES or NO (Please circle one)

3.) Have you noticed change in walking pace?
YES or NO (Please circle one)

4.) Do you get leg swelling, leg tiredness or discomfort caused by walking and relieved with rest?
YES or NO (Please circle one)

5.) Do you have pain in the legs at rest?
YES or NO (Please circle one)

6.) Do you have pain, sores, or wounds not healing completely on toes, feet, or legs?
YES or NO (Please circle one)

7.) Do you see color change or is skin cool to the touch in the legs?
YES or NO (Please circle one)

8.) Are you waking up at night because of leg discomfort?
YES or NO (Please circle one)

9.) Do you have poor nail growth on toes or decreased hair growth on legs?
YES or NO (Please circle one)

If you answered **YES** to any of the answers on the questionnaire, please follow up with your Physician or call us for a consultation.

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