Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Are you a diabetic? | Circle: YES/ NO |
| Do you smoke? | Circle: YES/ NO |
| Do you have uncomfortable aching, fatigue, tingling, numbness, cramping or pain in your feet, calves, or thigh while walking/exercise? | 1 – NO discomfort  2  3  4  5 – HIGH discomfort |
| Does the discomfort go away at rest? | Circle: YES/ NO |
| Do you experience leg or foot pain while at rest? | 1 – NO pain  2  3  4  5 – HIGH pain |
| Do you ever experience cold feet? | Circle: YES/ NO |
| Are you able to walk a block or more? | Circle: YES/ NO |
| How far can you walk? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any wounds on your feet or discoloration of toes that are not healing? | Circle: YES/NO |

Reviewed Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_