CARDIOVASCULAR ASSOCIATES OF RHODE ISLAND
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? ____
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    ____
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