BENENATI FOOT AND ANKLE CARE CENTERS

Patient Questionnaire

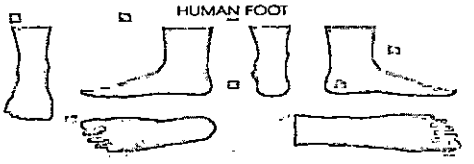
Please complete before seeing the Dr.

NAME:_____

DATE:_____

1. Do you have Diabetes? Yes No
2. Do you smoke or have you ever smoked? Yes No
3. Do you have high blood pressure? Yes No
4. Do you have high cholesterol? Yes No
5. Have you ever had a heart attach or stroke? Yes No
6. Have you ever had angioplasty or a stent? Yes No
7. Have you noticed your walking pace has slowed? Yes No
8. Do your legs ever feel tired causing you to stop and rest? Yes No
9. Do you ever have a dull, cramping pain the legs or feet when you walk, exercise or climb stairs? Yes No

   If applicable, draw a circle on the area of the body where you feel pain on the diagram on the.



10. Do you ever experience cramping, tightness, "Charlie horses" or pain in the legs or feet wen lying down that improves when you stand up? Yes No
11. Do you have infections or sores that are not healing on your feet or toes? Yes No
12. Is the skin on your legs or feet either pale, reddish or purple? Yes No
13. If you have toe nails are, they thick and hard? Yes No