PULSE VOLUME RECORDING

PATIENT HISTORY

NAME: _____ **Gender**: **M F** **Height**: _____ **Weight**: _____

Date of Birth: _____ **Referring Physician**: _____

Have you ever been treated for or are you currently being treated for:

High Blood Pressure	**Yes** ☐	**No** ☐
Did you take blood pressure medication today	**Yes** ☐	**No** ☐
Diabetes	**Yes** ☐	**No** ☐
Lung Disease	**Yes** ☐	**No** ☐
Kidney Disease	**Yes** ☐	**No** ☐
Vascular Surgery	**Yes** ☐	**No** ☐
Have you ever had a carotid ultrasound	**Yes** ☐	**No** ☐
Have you ever had a mastectomy	**Yes** ☐	**No** ☐
Are you a smoker	**Yes** ☐	**No** ☐

If yes How long have you smoked ? _____ How many packs per day?_____

Have you ever smoked?	**Yes** ☐	**No** ☐

If yes, when did you quit? _____

How long did you smoke? _____ How many packs per day? _____

Are you experiencing any of the following? If so please check which leg/legs and how long

Leg cramping or pain when walking or exercising	Right leg ☐	Left Leg ☐	How long? _____
Leg cramping or pain when resting	Right leg ☐	Left Leg ☐	How long? _____
Leg ulcers or sores	Right leg ☐	Left Leg ☐	How long? _____
Gangrene of legs or toes	Right leg ☐	Left Leg ☐	How long? _____
Extremity trauma	Right leg ☐	Left Leg ☐	How long? _____
Discoloration of legs, feet or toes	Right leg ☐	Left Leg ☐	How long? _____
Extreme sensitivity to cold (feet and/or toes)	Right leg ☐	Left Leg ☐	How long? _____

Additional comments:

_____

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_____

_____

For office use:

MRN: _____ ACC : _____