

PERIPHERIAL VASCULAR DISEASE QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. When was the first time you noticed any problems with your limbs?

2. At that time, do/did you have any other impairments that could have been a factor, if so, please explain? _____

3. Have you ever had any studies completed due to your peripheral vascular disease? _____

4. Please indicate the name and address of your physician _____

5. Are you a smoker? _____
6. Have you ever been advised to stop smoking? _____

7. Do you use alcohol, if so, how much? _____

8. Have you ever had any surgeries for your peripheral disease? _____

9. Have you ever been diagnosed with any other impairment (ie; high blood pressure, diabetes, heart), if so, what other impairment and when was it diagnosed? _____

10. Are you on any medications, if so, please explain? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo