Patient Questionnaire for Symptoms Suggestive of Autonomic Dysfunction:

Question	Yes	No
1. Do you have diabetes? If yes, answer questions 2 and 3; if no, skip to question 4		
2. Have you had low blood sugar (with our without fainting) and not been aware of it?		
3. Do you sweat when you eat, even if the food is not spicy, or do you have dry skin on your hands or feet?		
4. Do you have pain, tingling, burning, numbness, or electrical shocks in your feet? Circle which symptom(s) you have		
5. Do the bedsheets or your socks bother or hurt your feet?		
6. Do you have pain, tingling, burning, numbness, or electrical shocks in your hands? Circle which symptom(s) you have		
7. Do you have trouble driving or seeing at night?		
8. Do you feel dizzy or faint when you stand up too quickly?		
9. Do you feel bloated or full after the first few bites of food?		
10. Do you get tired as soon as you start to exercise?		
11. Do you have diarrhea at night?		
12. Do you have urinary incontinence?		
13. Men only: do you have difficulty with erections that has not improved with medications like Viagra or Cialis?		

Patient Name:_____

AMERICAN HEART ASSOCIATION PAD SURVEY

Patient Name:_____

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

Do you experience any pain in your legs or feet while at rest?	Yes No
Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
Do your feet get pale, discolored or bluish at any time during the day?	Yes No
Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
Do you have diabetes?	Yes No
Do you have a history of chronic kidney disease?	Yes No
Do you currently or have you ever smoked?	Yes No
Do you have a history of stroke or mini-stroke (TIA)?	Yes No
Do you have a history of heart disease (heart attack, MI)?	Yes No
Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No