ProActive
HEART & VEIN CENTER

Patient Name: ______________________________ **Date:** ____________

We need to know all the medications you are taking so that we do NOT prescribe medication(s) that will interfere with others you are taking, that may have been prescribed by other physicians. It is very important that you list ALL the medications you take currently, including "over the counter" medications.

Medication Name	Dosage	How many times/day

If more space is needed use back of page.

I am allergic to the following medications:

LIVING WILL

I have an Advance Health Care Directive or LIVING WILL (instructions about your own health care, or have named someone else to make health care decisions for you).

□ YES □ NO (Check one) ♦ *If yes, please provide a copy for us to put in your file.*

Please fill out this brief questionnaire to assist us in providing you with the best care possible.

Check all that apply:

□ Do you have pain, cramping, aching, numbness, tiredness, weakness or burning in your buttock, thigh, calf or foot?
□ Do you have restless legs?
□ Do you have numbness is your legs or feet?
□ Does your skin appear pale and feel cool to the touch?
□ Do you have foot or toe pain or tingling that does not go away with rest?
□ Do you have a feeling that the hip or leg is "giving out" while walking?
□ Do you have skin wounds, sores, infections or ulcers on your legs or feet that heals slowly or does not heal at all?
□ Do you have swelling of ankles or lower legs?
□ Do you have heavy, tight or achy legs?
□ Do you have varicose veins or spider veins?
□ Do you have skin that becomes discolored, feels leathery, flaky and/or itchy?
□ Do you have chest pain?
□ Do you have shortness of breath?