Risk Assessment for Heart, Vascular and Lungs

Name: _____ **Date of Birth:** _____

1)	**Are you diabetic?**	**Yes/No**
2)	**Do you smoke?**	**Yes/No**
3)	**When you walk or exercise, do you experience aching, cramping or pain in the arms/logs/buttocks?**	**Yes/No**
4)	**If you answered yes, does the pain subside with rest?**	**Yes/No**
5)	**Do you experience pain, aching or cramping in arms/legs/buttocks at REST?**	**Yes/No**
6)	**Do you have any painful sores or ulcers on your legs or feet that are not healing?**	**Yes/No**
7)	**Do you feel that you have poor circulation in your legs?**	**Yes/No**

Total circled "Yes" _____