-Vascular-
-Independent Research and Education-
European Organisation

Visit Date --/--/--

Barcode

Patient Information Sheet

Pt. Name: _____
Phone (Home): _____
(Work): _____
Spouse Name: _____
Occupation: _____

Address _____

The patient signed the informed consensus on

--/--/--

PATIENT HISTORY

1. Born in
2. Date of Birth month day year __/__/
3. Male [] Female []
4. Height Weight
5. Current marital status?

Married [] Partnered [] Widowed [] Divorced [] Separated [] Never married []
Not married but living together []

How long ? ----/-- (years/months)

6. Years of formal education? Years

7. Employment status?
Working full-time [] Retired [] Disable [] Working part-time [] Unemployed []

8. State/province?

9. Country -------

10.Ethnic group?

[] White/European
[] Black/African
[] Asian Indian or Pakistani
[] Asian

Ask about diet, smoking history and alcoholic beverages

Diet History

a. Is the patient currently on any special diet? Yes [] No []

b. If yes, please specify the type of special diet:

[] Vegetarian (specify)_____
[] Low fat (specify)_____
[] Low salt (specify)_____
[] Weight loss (specify)_____
[] Diabetic (specify)_____
[] Other (specify)_____

Smoking History

a. Does he/she currently smoke? Yes [] No []

a1 How long has he/she been smoking for? _____
a2 What does he/she smoke? Cigarettes []
Cigar []
Pipe []
a3 How much does he/she smoke? _____

b. Has he/she definitively quit smoking? Yes [] No []

b1 When did he/she quit? _____
b2 How long had he/she been smoking for? _____
b3 What did he/she use to smoke? Cigarettes []
Cigar []
Pipe []
b4 How much did he/she use to smoke? _____

c. Has he/she ever stopped smoking in the past? Yes [] No []

c1 If Yes how many times? _____

Alcoholic history

1. Over a week how many days does he/she drink alcohol : days per week ? --/--
2. On the day(s) he/she drinks alcoholic beverages, how many drinks does he/she have per day, on average? Drinks per day ? --/--
3. How long has he/she been a drinker for? Years?
4. What does he/she usually drink? Beer Wine Strong alcohol
| __| | __| |__|

Currently exercise

Does he/she currently exercise ?
Walking [] Weights [] Do not exercice []
Cycling [] Swimming []
Other [] (specify)_____

How often does he/she exercise --/-- (times per week)
How long does he/she exercise --/ (minutes)
How long has he/she been exercising for -- (year)
Supervised exercise on treadmill (hospital) Yes [] No []
How long has he/she been supervised for _____

Medical History

Attention: in case of manual filling please write the code referring to each pathology in the space provided before the disease category name. The exact code would be found on the diseases file you should print before filling this form.

Select code		code	code	code
1-	Acute rheumatic fever	_ _ _	_ _ _	_ _ _
2-	Chronic rheumatic heart diseases	_ _ _	_ _ _	_ _ _
3-	Hypertensive diseases	_ _ _	_ _ _	_ _ _
4-	Ischaemic heart diseases	_ _ _	_ _ _	_ _ _
5-	Pulmonary heart disease and diseases of pulmonary circulation	_ _ _	_ _ _	_ _ _
6-	Other forms of heart disease	_ _ _	_ _ _	_ _ _
7-	Cerebrovascular diseases	_ _ _	_ _ _	_ _ _
8-	Diseases of arteries, arterioles and capillaries	_ _ _	_ _ _	_ _ _
9-	Diseases of veins, lymphatic vessels and lymph nodes	_ _ _	_ _ _	_ _ _
10-	Other and unspecified disorders of the circulatory system	_ _ _	_ _ _	_ _ _
11-	Metabolic disorders	_ _ _	_ _ _	_ _ _

*the codes have been taken from theWHO's classificationof diseases

Neuropathy	Yes []	No []
Degenerative joint disease/ rheumatoid arthritis	Yes []	No []
Arthritis	Yes []	No []
Kidney trouble	Yes []	No []
Liver disease	Yes []	No []
Hepatitis	Yes []	No []
Cancer	Yes []	No []
If Diabetic, the date of your last eye exam:	--/--/-- (month day year)	

Interventional history

PTCA (heart angioplasty)	Yes []	No []	Date of surgery --/--/--
Angioplasty (legs)	Yes []	No []	Date of surgery --/--/--
Angioplasty (carotids)	Yes []	No []	Date of surgery --/--/--
Laser/radiof. varicosities therapy	Yes []	No []	Date of surgery --/--/--

Other: (please specify): _____

Surgical history

Coronary artery bypass surgery	Yes	[]	No	[]	Date of surgery --/--/--
Leg bypass surgery	Yes	[]	No	[]	Date of surgery --/--/--
Abdominal aortic aneurysm	Yes	[]	No	[]	Date of surgery --/--/--
Carotid artery surgery	Yes	[]	No	[]	Date of surgery --/--/--
Vein surgery	Yes	[]	No	[]	Date of surgery --/--/--

Other: (please specify): _____

Family history of any of the following diseases

High blood pressure	Yes	[]	No	[]	Uunknown	[]
Thrombophilia	Yes	[]	No	[]	Uunknown	[]
Diabetes	Yes	[]	No	[]	Uunknown	[]
Cancer	Yes	[]	No	[]	Uunknown	[]
Heart problems	Yes	[]	No	[]	Uunknown	[]
Stroke	Yes	[]	No	[]	Uunknown	[]
High Cholesterol	Yes	[]	No	[]	Uunknown	[]
Asthma	Yes	[]	No	[]	Uunknown	[]
Immunological diseases	Yes	[]	No	[]	Uunknown	[]
Obesity	Yes	[]	No	[]	Uunknown	[]

Current medication

Please list all medications that currently taking

Class	Medication	Dose	How often	Route : I.V.; I.M., subcutaneous; Oral, Oral sustained release; PCA pump	Date started (mm/gg(yy)	Reason

TEST essential	normal	hight Value	low Value
White Blood Cell	[]	[] _ _._	[] _ _._
Hemoglobin	[]	[] _ _._	[] _ _._
Hematocrit	[]	[] _ _._	[] _ _._
Platelet	[]	[] _ _._	[] _ _._
RBC	[]	[] _ _	[] _ _
Creatinine	[]	[] _ _	[] _ _
Glucose	[]	[] _ _	[] _ _
Total Cholesterol	[]	[] _ _	[] _ _
Triglycerides	[]	[] _ _	[] _ _
HDL	[]	[] _ _	[] _ _
LDL	[]	[] _ _	[] _ _
VLDL	[]	[] _ _	[] _ _
Insulin	[]	[] _ _	[] _ _
C-reactive peptide	[]	[] _ _	[] _ _
TEST if possible			
Lipoprotein (a)	[]	[] _ _ _	[] _ _ _
Homocysteine	[]	[] _ _ _	[] _ _ _
D-dimer	[]	[] _ _ _	[] _ _ _
Fibrinogen	[] _ _ _	[] _ _ _	[] _ _ _

LEAD ECG (Pre-ETT)

Heart Rate (bpm) |__|__||__|

1	☐	Sinus rhythm
2	☐	Sinus bradycardia
3	☐	Sinus tachycardia
4	☐	Atrial premature beats
5	☐	Atrial fibrillation
7	☐	1° AV Block
8	☐	Ventricular premature beats (VPB)
9	☐	Left axis deviation
10	☐	Right axis deviation
11	☐	ST segment depression
12	☐	LBBB
13	☐	RBBB
14	☐	LVH
15	☐	Myocardial infarction
15a	☐	Anterior
15b	☐	Posterior
15c	☐	Inferior
15d	☐	Lateral
15e	☐	Septal
16	☐	Nonspecific ST-T wave changes
17	☐	ST segment elevation
18	☐	Comment_____

_____

_____

Physical Examination Study

Exam	Physical Exam	Comments (if abnormal)
Neurological	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Skin	1 □ Normal 2 □ Abnormal 0 □ Deferred	
HEENT (Head, eyes, ears, nose,throat)	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Cardiac	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Lungs	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Abdomen	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Genitourinary	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Peripheral Vascular	1 □ Normal 2 □ Abnormal 0 □ Deferred	
Lymphatic	1 □ Normal 2 □ Abnormal 0 □ Deferred	

Vital Signs:

Height:	_ _ _ cm
Weight:	_ _ _ Kg
BMI:	_ _ ._ _
Waist circumference (WC)	_ _ _ cm
Hip circumference (HC)	_ _ _ cm
Waist-to-hip ratio (WHR)	_. _ _
Blood Pressure I (sitting):	_ _ _ /_ _ _ mmHg
Blood Pressure II (sitting):	_ _ _ /_ _ _ mmHg
Heart Rate I:	_ _ _ beats per minute
Heart Rate II:	_ _ _ beats per minute
Respiratory Rate:	_ _ per minute
Temperature:	_ _ ._ °C

Genetic Determinants of PAD

In what country were your **grandparents** from? (if you do not know the exact country, enter the name of the continent or mark "unkn" if completely unknown.)

Mother's Mother	Father's Mother
Mother's Father	Father's Father

Please indicate your ancestry or ethnic background of your biological (not adopted) grand-parents by completing the following table. If you do not know their exact ethnic background, please mark unknown. You may fill in more than one response for each person.

Ethnic Background	Mother's Mother	Mother's Father	Father's Mother	Father's Father
White/European	□	□	□	□
Black/African	□	□	□	□
Asian Indian or Pakistani	□	□	□	□
Asian	□	□	□	□

Ankle/Brachial Index (Qualifying)

Pre-exercise (systolic) artery pressure measurements for qualification (Doppler)

	Right	**Left**
Brachial	_ _ _ mmHg	_ _ _ mmHg
Ankle-Dorsalis Pedis	_ _ _ mmHg	_ _ _ mmHg
Ankle-Posterior Tibial	_ _ _ mmHg	_ _ _ mmHg
Ankle/Brachial Index (ABI)	_°_ _	_°_ _
(Highest ankle pressure divided by highest brachial pressure)	1□ DP 2□ PT	1□ DP 2□ PT

Choose the leg with the lowest ABI and the ankle artery with the highest pressure in that leg for all subsequent measurements.

Mandatory if ABI>0.9

	Right	**Left**
TOE	_ _ _ mmHg	_ _ _ mmHg
TOE Index	☐	☐

Classify your patient following the ABI and TOE Index data :

ABI <0.9	PAD |__|
ABI >0.9 and /or TOE Index <0.7 at least in one leg	PAD |__|
ABI >0.9 and /or TOE Index >0.7 at least in one leg	CONTROL |__|

FONTAINE CLASSIFICATION		RUTHERFORD CLASSIFICATION		
Stage	Clinical Description	Grade	Category	Clinical Description
I	Asymptomatic	0	0	Asymptomatic
IIa	Mild claudication	I	1	Mild claudication
IIb	Moderate-to-severe claudication	I	2	Moderate claudication
		I	3	Severe claudication
III	Rest pain	II	4	Rest pain
IV	Ulceration or gangrene	III	5	Minor tissue loss
		IV	6	ulceration or gangrene

Absolute Claudication Distance (ACD) metres_____

Relative Claudication Distance (RCD) metres_____

Please specify your Treadmill :
- Speed Km/h----------
- Slope %

Notes ----------

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