# PULSE VOLUME RECORDING

## Patient History

Name: ________________________________ Gender: M F

Home Phone: __________-__________ DOB: ______/______/______

Referring Physician: ________________________________

**Have you *ever been treated* or are you *currently being treated* for:**

| | | | |
|---|---|---|---|
| *High Blood Pressure* | ☐ | *Heart Disease* | ☐ |
| *Smoker **(past/present)*** | ☐ | ***Carotid (neck) Ultrasound*** | ☐ |
| *Diabetes* | ☐ | *Lung Disease* | ☐ |
| *High Cholesterol* | ☐ | *Kidney Disease* | ☐ |

**Are you experiencing any of the following?**

| | RIGHT Leg | LEFT Leg |
|---|---|---|
| ***Leg cramping or pain when walking or exercising*** | | |
| ***Leg cramping or pain when resting*** | | |
| ***Leg ulcers or sores*** | | |
| ***Gangrene of legs or toes*** | | |
| ***Extremity trauma*** | | |
| ***Discoloration of legs, feet or toes*** | | |
| ***Lack of pulse at base of feet*** | | |
| ***Extreme sensitivity to cold (feet and/or toes)*** | | |

**Cc Results:** ________________________________

IMAGECARE

22-July-05