PERIPHERAL VASCULAR DISEASE/DEXA SCREENING

Patient Name: _____ Physician: _____ DOB: _____

Are you experiencing any of these conditions/symptoms/signs?

Venous Reflux Disease (VRS):	
Leg discoloration:	Yes / No / Sometimes
Leg fatigue:	Yes / No / Sometimes
Leg Pain:	Yes / No / Sometimes
Leg Swelling:	Yes / No / Sometimes
Varicose Veins:	Yes / No / Sometimes
Leg Numbness:	Yes / No / Sometimes
Foot tingling:	Yes / No / Sometimes
Leg/foot sores:	Yes / No / Sometimes
Leg/foot dryness:	Yes / No / Sometimes

Peripheral Arterial Disease (PAD):	
Smoking:	Yes / No / Sometimes
High Cholesterol:	Yes / No / Sometimes
High Blood Pressure:	Yes / No / Sometimes
Diabetes Mellitus:	Yes / No
Heart Disease:	Yes / No / Sometimes
Calf pain walking:	Yes / No / Sometimes
Calf/buttock pain at rest:	Yes / No / Sometimes
Non healing ulcers in legs:	Yes / No / Sometimes
Artery disease/plaque in arteries:	Yes / No / Sometimes
Age > 60:	Yes / No

Any risk factors for VRS:

☐ **Refer for Venous Reflux Scan (if positive refer to vein clinic**
Perform ABPI if available or refer to PAD clinic, if indicated

If there are 2 or more risk factors of PAD:

☐

Criteria for having a DEXA Scan

Conditions

- ☐ All women 65 years of age or older
- ☐ All men age 70 years and older
- ☐ Men under age 70 with risk fractures for fracture
- ☐ Postmenopausal woman under age 65 with risk factors or fracture
- ☐ Adults with a disease or condition associated with low bone mass or bone loss (hyperparathyroidism, chronic liver/kidney disease, malabsorption, eating disorders)
- ☐ SHPT associated with kidney disease
- ☐ Men younger than 70 with testosterone deficiency

Risk Factors

- ☐ Body weight less than 127 pounds
- ☐ Family history of osteoporosis or fragility fracture
- ☐ Personal history of fracture in adulthood
- ☐ Current cigarette smoker
- ☐ More than 1 alcohol drink per day
- ☐ Use of high-risk medications
  - Steroids (prednisone)
  - Thyroid replacement
  - Antidepressants
  - Anti-epileptics
  - Cyclosporine
  - Loop diuretics
  - Proton pump inhibitors
- ☐ Eating disorders (past or current)

Was your last DEXA screen more than 2 years ago? ☐ **yes** ☐ **no** Date of last scan: _____ ☐ **N/A**

(We recommend DEXA scan every 2 years if you meet criteria)

Order DEXA scan ☐ **YES** ☐ **NO**

Physician Signature: _____ Date: _____

Revised 06/2017-RL