apple health &wellness

Patient Name: _____

Date: _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework , or school activities	**0**	**1**	**2**	**3**	**4**
2	Your usual hobbies, recreational or sporting activities	**0**	**1**	**2**	**3**	**4**
3	Getting into or out of the bath.	**0**	**1**	**2**	**3**	**4**
4	Walking between rooms.	**0**	**1**	**2**	**3**	**4**
5	Putting on your shoes or socks.	**0**	**1**	**2**	**3**	**4**
6	Squatting.	**0**	**1**	**2**	**3**	**4**
7	Lifting an object, like a bag of groceries from the floor.	**0**	**1**	**2**	**3**	**4**
8	Performing light activities around your home.	**0**	**1**	**2**	**3**	**4**
9	Performing heavy activities around your home.	**0**	**1**	**2**	**3**	**4**
10	Getting into or out of your car.	**0**	**1**	**2**	**3**	**4**
11	Walking 2 blocks.	**0**	**1**	**2**	**3**	**4**
12	Walking a mile.	**0**	**1**	**2**	**3**	**4**
13	Going up or down 10 stairs (about 1 flight of stairs).	**0**	**1**	**2**	**3**	**4**
14	Standing for 1 hour.	**0**	**1**	**2**	**3**	**4**
15	Sitting for 1 hour.	**0**	**1**	**2**	**3**	**4**
16	Running on even ground.	**0**	**1**	**2**	**3**	**4**
17	Running on uneven ground.	**0**	**1**	**2**	**3**	**4**
18	Making sharp turns while running fast.	**0**	**1**	**2**	**3**	**4**
19	Hopping.	**0**	**1**	**2**	**3**	**4**
20	Rolling over in bed.	**0**	**1**	**2**	**3**	**4**
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

Score: _____/80

Please sumbit the sum of responses.

Peripheral Vascular Screening

Circle "Yes" or "No":

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk or exercise which is relieved by rest? YES or NO
2. Do you experience any pain at rest in your lower leg(s) or feet? YES or NO
3. Do you experience foot or toe pain that often disturbs your sleep? YES or NO
4. Are your toes or feet pale, discolored, or bluish? YES or NO
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? YES or NO
6. Has your doctor ever told you that you have diminished or absent Pedal (foot) pulses? YES or NO
7. Have you suffered a severe injury to the leg(s) or feet? YES or NO
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? YES or NO
9. Have you had surgery, balloon procedures, or stents in your arms, legs, or heart? YES or NO
10. If you have any of the below conditions, please circle them:
    Diabetes | High Cholesterol | History of Smoking | High Blood Pressure | Coronary Heart Disease
11. Would you be interested in a noninvasive peripheral vascular test performed in office? YES or NO