

Name _____ DOB _____

Fistula Mapping Questionnaire - Please be thorough in completing this form - Check all that apply to you:

Have you had:

- Previous dialysis access?
 - catheter, specify: _____
 - fistula or graft, specify: _____
- PICC line or other catheters in your arms, specify: _____
- Pacemaker / Defibrillator, specify: _____
- Angiogram through your wrist artery, specify: _____
- Blood clots in your arms, specify: _____

List the name of your nephrologist: _____

Are you receiving dialysis:

- No
- Hemodialysis – name of dialysis center: _____ Days: Mon/Wed/Fri Tue, Th, Sat
- Peritoneal dialysis

Are you:

- right handed left handed

Is kidney transplant planned:

- Yes No

Do you have history of:

- Coronary artery disease / Heart attack
- Stroke
- Congestive heart failure
- Cancer, specify: _____
- Diabetes: type I type II
- Smoking: Current smoker Former smoker
- Peripheral arterial disease:
 - Have you had prior leg procedure
 - angioplasty / stent of arteries in legs
 - leg bypass
 - amputation → leg: _____ foot/toe: _____
 - vein stripping / phlebectomy in your legs vein sclerotherapy vein closure: _____
 - Do you have:
 - Open sores or ulcers on your leg(s) or feet that will not heal?
 - Leg pain / discomfort? → right leg left leg both legs