MINIMALLY INVASIVE VASCULAR CENTER

VASCULAR ASSESSMENT

Patient information

Name:	Date:
Primary reason for visit:	

Circle **Yes** or **No** to the following questions:

Do you have heart problems?	Yes	or	No
Do you have High Blood Pressure?	Yes	or	No
Do you have Diabetes?	Yes	or	No
Are you age 50 or older?	Yes	or	No
Do you eat fried or fatty foods?	Yes	or	No
Are you suffering from high cholesterol?	Yes	or	No
Do you have a family history of cardiovascular disease?	Yes	or	No
Do you experience leg cramps or leg pain when you walk?	Yes	or	No
Do you have tingling or numbness in your hands or feet?	Yes	or	No
Do you have sores on your legs or feet that won't heal?	Yes	or	No
Discoloration of the skin on your legs?	Yes	or	No
An inactive lifestyle?	Yes	or	No
Do you smoke?	Yes	or	No
Have you ever smoked?	Yes	or	No
Are you more than 25 pounds overweight?	Yes	or	No
How many times did you select yes?			

If you have checked Yes for three or more of the above condition you could be at risk for Cardiovascular Disease. This screening is intended to help you to identify risk factors associated with Vascular Disease and to encourage you to seek medical assistance as needed.