



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.