

Vascular Disease Patient Questionnaire



Patient Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ Today's Date _____

Phone _____ Primary Care Physician _____

Yes No 1. Are you over 70 yrs of age?

Yes No 2. Are you over 50 yrs of age and a smoker or diabetic?

Please circle the name of the physician you are seeing today: Schultz Kelly Lee

CEREBRAL VASCULAR *Have you experienced:*

Yes No 3. Any changes in your vision such as one eye going dark for a period of time?

Yes No 4. Have you noticed or been told that your speech was garbled/slurred?

Yes No 5. Have you noticed or been told that your lip was drooping?

Yes No 6. Have you noticed any changes in hand or leg strength, feeling or coordination?

Yes No 7. Arm or hand pain with activity such as combing your hair?

Yes No 8. Recurrent lightheadedness, or near fainting with head motion or the use of your arm?

Yes No 9. Have you been told that one arm is better for taking your blood pressure than the other?
If so, which one and why? _____

PERIPHERAL VASCULAR

Yes No 10. Do you have high blood pressure?

10.a If yes, are you on more than 2 medications?

Yes No 11. Have you lost weight in the past 3 months?

Yes No 12. Has your appetite changed?

Yes No 13. Have you ever had pain in your abdomen after eating?

Yes No 14. Do you have burning or cramping pain in your legs with walking?

If yes, please circle location: Buttocks Thighs Calfs (lower legs)

How far can you walk? _____

Yes No 15. Do you have pain in your feet at night that is only improved with standing?

Yes No 16. Are your feet always cold?

Yes No 17. Are your feet bright red in color?

Yes No 18. Do you have a sore on your foot that has been there for more than 10 days?

ANEURYSMAL DISEASE

Yes No 19. Do you have a known Aneurysm?

Yes No 20. Has anyone in your family ever been diagnosed as having an aneurysm?

If yes, how and where at on the body? _____

Yes No 21. Are you a man over 65 years of age?

VENOUS DISEASE

Yes No 22. Do you have leg swelling?

Yes No 23. Do you have painful varicose veins? _____

If yes, which leg? Right _____ Left _____

What are your main symptoms? _____

Yes No Have you tried compression stocking? Yes No

How long? _____

Yes No 24. Have you ever had an open sore between your knee and ankle that took a long time to heal?

Yes No 25. Have you ever been told you have high cholesterol?

Levels if known: HDL _____ LDL _____ Triglycerides _____