COMMONWEALTH VASCULAR INSTITUTE

VASCULAR PATIENTS QUESTIONAIRE

Patient Name: _____ Date of Birth: _____

CARDIOVASCULAR:

Are you being treated for high blood pressure?	☐YES	☐NO
If yes, how many medications do you take for this? _____		
Do you take medication for cholesterol?	☐YES	☐NO
Have you ever had a heart attack?	☐YES	☐NO
Do you have chest pain?	☐YES	☐NO
Do you take nitroglycerin?	☐YES	☐NO
Have you had coronary bypass surgery (open heart surgery)?	☐YES	☐NO
Have you had stents placed in your heart?	☐YES	☐NO
Are you being treated for an abnormal heart rhythm?	☐YES	☐NO
Do you have a Pacemaker or Defibrillator?	☐YES	☐NO

SMOKING STATUS:

Do you currently smoke?	☐YES	☐NO
How many packs per day? _____Pk(s)		
Previous History of smoking?	☐YES	☐NO
How many years ago did you quit smoking? _____ Yr(s)		

ENDOCRINE:

Are you a DIABETIC?	☐YES	☐NO
Are you on Insulin?	☐YES	☐NO
Do you take diabetic medication by mouth?	☐YES	☐NO
Do you have Type 1(Juvenile) or Type 2 (adult onset)?	☐Type 1	☐Type 2

SURGICAL HISTORY:

Have you had any of the following surgeries?

Carotid artery surgery	☐YES	☐NO
Bypass graft in your legs	☐YES	☐NO
Dialysis shunt or fistula in your arm or leg	☐YES	☐NO
Aortic Aneurysm Surgery (abdomen)	☐YES	☐NO
Are you being treated for any type of lung disease?	☐YES	☐NO
Do you currently have an aortic aneurysm?	☐YES	☐NO
Do your legs hurt when you walk?	☐YES	☐NO

VASCULAR PATIENTS QUESTIONAIRE

VENOUS HISTORY:

Have you ever had a blood clot in your leg? ☐YES ☐NO

Have you ever had a blood clot in your arm? ☐YES ☐NO

Have you ever had a blood clot in your lung? ☐YES ☐NO

Have you ever had a catheter or line placed in your neck or chest? ☐YES ☐NO

Are you currently being treated for Cancer? ☐YES ☐NO

If yes, what kind? _____

Do you take blood thinners? ☐YES ☐NO

☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Eliquis ☐ Xarelto ☐Other: _____

Have you injured your leg or arm recently? ☐YES ☐NO

If yes, ☐Leg ☐Arm

Do you take Hormones? ☐YES ☐NO

Has your doctor ever said you have varicose veins? ☐YES ☐NO

Have you had surgery in the past 3 months? ☐YES ☐NO

Have you had your veins stripped or used for open heart surgery? ☐YES ☐NO

If yes, which leg did you have surgery on? ☐Right ☐Left ☐Both

Is your doctor planning to do bypass surgery? ☐YES ☐NO

Which hand do you write with? ☐Right ☐Left

_____

Patient Signature

_____ _____

Printed Name Date