COMMONWEALTH VASCULAR INSTITUTE

VASCULAR QUESTIONNAIRE

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
Have you had coronary bypass surgery or stents?	☐YES	☐NO
Are you being treated for an abnormal heart rhythm?	☐YES	☐NO
Do you have a Pacemaker or Defibrillator?	☐YES	☐NO
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)		
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:

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

VENOUS HISTORY:

Have you ever had a blood clot in your leg, arm, or lung?	☐YES	☐NO
Are you currently being treated for Cancer?	☐YES	☐NO
Do you take blood thinners?	☐YES	☐NO

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

_____ _____

Patient Name DOB