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1216 Florida Dr. Suite 130 Arlington TX 76015 (817) 461-6374

Cardiovascular Screening Questionnaire

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| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please circle the information below that pertains to you.**

|  |  |  |
| --- | --- | --- |
| * Do you have a stressful life style? | Yes | No |
| * Are you over age 35? | Yes | No |
| * Do you or your family have a history of cardio vascular (heart) disease, heart attacks, or strokes? Please circle-- 1) you 2)family | Yes | No |
| * Suffer from dizziness/light-headedness/fainting? * Do you have atrial fibrillation (irregular heartbeat)? | Yes  Yes | No  No |
| * Do you smoke now or in the past? | Yes | No |
| * Do you have a high fat and/or high sugar diet? | Yes | No |
| * Do you take birth control pills? | Yes | No |
| * Do you tire/fatigue easily after common physical activities? | Yes | No |
| * Do you suffer from headaches? * Do you ever experience slurred speech? | Yes  Yes | No  No |
| * Do you exercise regularly? | Yes | No |
| * Do you sleep at least 7 hours a night? | Yes | No |
| * Do you eat three balanced meals a day? | Yes | No |
| * Do you bruise easily? | Yes | No |
| * Do you have any swollen or stiff joints? | Yes | No |
| * Do you have varicose veins? | Yes | No |
| * Do you take medication for cholesterol, blood pressure, or high triglycerides? **Circle all that apply** | Yes | No |
| * Do you suffer from Diabetes? | Yes | No |
| * Do you experience tingling/numbness in arms/legs? If yes, **Arms or Legs?** | Yes | No |
| * Do you have radiating pain from neck into the arms, or low back into legs? If yes, **Neck into arms/Low back into legs?** | Yes | No |
| * Have you had neck pain or low back pain for 6 months or longer? If so, **Neck or Low back?** | Yes | No |
| * Do you have extremity pain in arms or legs? If so, **Arms or Legs?** | Yes | No |
| * Have you had recent weakness in arms or legs? If so, **Arms or Legs?** | Yes | No |
| **(Example of weakness) Lack of hand grip, or legs not functioning correctly** | | |

Additional Comments (internal use only)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Additional Comments from Technician only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_