CYPRESS DIAGNOSTIC IMAGING

Patient name: _____ Date: _____ Date of Birth: _____

Early Detection Leads to Prevention!

Cardiac and Vascular Health Questionnaire: (please circle "Yes" or "No")

Are you a male over age 45 or female over age 55? ..... Yes / No

Do you have a family history of stroke or TIA? ..... Yes / No

Do you have family history of an Abdominal Aortic Aneurysm? ..... Yes / No

Do you have high blood pressure or take blood pressure medication? ..... Yes / No

Do you have high cholesterol or triglycerides? ..... Yes / No

Has anyone in your immediate family (father, mother, sister, brother, grandparents, aunts or uncles (blood relatives) been diagnosed with cardiovascular disease? ..... Yes / No

When you stand up do you ever feel light headed or dizzy? ..... Yes / No

Do you ever feel vertigo? ..... Yes / No

Have you ever been diagnosed with a heart murmur? ..... Yes / No

Do you ever experience chest pain or chest tightness? ..... Yes / No

Do you have heart palpitations or heart "flutters"? ..... Yes / No

Have you ever been diagnosed with any type of heart ailment, heart disease or cardiovascular disease? ..... Yes / No

Do you have diabetes? ..... Yes / No

Are you a current or former smoker? ..... Yes / No

Have you had a stroke/ mini-stroke/ TIA? ..... Yes / No

Do you experience migraines or periodic headaches? ..... Yes / No

Have you ever had a sudden loss of vision in one eye, usually lasting only seconds? ..... Yes / No

Do you have varicose veins? ..... Yes / No

Have you had swollen legs or feet in the past year? ..... Yes / No

Have you had leg pain in the past year? ..... Yes / No

Do your feet or toes bother you at night while lying in bed? ..... Yes / No

When walking or exercising do you get leg pain, tingling, or cramping? ..... Yes / No

Do you have or easily get cold hands or feet? ..... Yes / No