CVS
Cardio Vascular Services

PATIENT QUESTIONNAIRE - VASCULAR

☐ Dr ☐ Miss ☐ Ms ☐ Mrs ☐ Mr		
First Name	**Middle Initial**	**Last Name**

Postal Address:		**Date of Birth:**	
Emergency / Next of Kin Name:		**Next of Kin Relationship:**	
Telephone 1		**Telephone 2**	

Medications - Please list all the medications (including herbal medicines) you are taking:

Referring Doctor:		**Suburb:**	
Usual GP:		**Suburb:**	
Other Interested Parties:		**Suburb:**	
Follow up date:			

Medical History	**Height:**		**Weight:**	
Have you been told of a problem with your arteries or veins? What was it?				Yes / No
Have you been diagnosed with or treated high blood pressure / hypertension?	Yes / No	Do you have elevated cholesterol?		Yes / No
Have you been told you have a problem with your lower back or hips?	Yes / No	Have you received chemotherapy or radiotherapy?		Yes / No
Have you been diagnosed with Diabetes?	Yes / No	Do you currently smoke?		Yes / No
Are you an ex-smoker?	Yes / No	Have you ever had a pulmonary embolism?		Yes / No
Have you ever had leg ulcers?	Yes / No	Do you have varicose veins?		Yes / No
Have you ever had a stroke?	Yes / No			
Has anyone in your direct family had vascular or heart disease? If so, Who?				Yes / No
Have you ever had deep vein thrombosis? If yes, in which vein and when?				Yes / No
Current Symptoms (experienced in the last 3 months):				
Do you experience dizziness?	Yes / No	Do you get swelling of the ankles (oedema)?		Yes / No
Have you been experiencing leg pain at rest?	Yes / No	Does the pain increase when you stand up for a long time?		Yes / No
Do your feet and toes get cold or painful when you lie down?	Yes / No			
Have you had any of the following tests performed?				
An injection or operation to a vein or artery? (Please provide details)				Yes / No
A previous test or scan done on your arteries or veins? (Please provide details)				Yes / No
Angioplasty (PTCA) or had stent/s inserted?	Yes / No	Coronary artery bypass surgery (CABG)?		Yes / No

Signature:		**Date:**	