

| Have you ever smoked (or u If yes, do you now? If yes, how much? When did you start? When did you stop? | Yes Yes | No No | | | |
|---------------------------------------------------------------------------------------------------------------------|------------------------|----------------|-------------------|-------------|--|
| Do you use alcohol? | Yes | No | Occasiona | ally | |
| How much? | | _How often | How often? | | |
| If you answer yes to any of t diagnosed: | the following questio | ons, please st | ate when you w | vere | |
| High Blood Pressure | Yes / No | | | | |
| High Cholesterol | Yes / No | | | | |
| Diabetic | Yes / No | | | | |
| Ever had a heart attack | Yes / No | If yes, wh | 1en? | | |
| Have you ever had any of th | e following: If yes, s | state diagno | sis date or proce | edure date: | |
| Ever been told you had a blo | ockage in your legs? | Yes / No | | | |
| Ever had a procedure relate | Yes / No | | | | |
| Heart Failure | | Yes / No | | | |
| History of Atrial Fibrillation? | Yes / No | | | | |
| Ever had a stent? | | Yes / No | | | |
| If yes, when and nan | | n/dd/yy) | (facility) | | |
| Ever had by-pass surgery? | Yes / No | | | | |
| If yes, when and nan | ne of facility: | (mm/dd/yy |) (facilit | | |



| Ever had a procedure related to your neck arteries? | | Yes / No | | | | | |
|--------------------------------------------------------|-----------------|------------------|----------------------|----------|--|--|--|
| | | / left / both: | | | | | |
| Ever had a procedure related to that | | nat problem? | Yes / No | | | | |
| Prior amputation related to Limb Isc | | schemia: | Yes / No | | | | |
| Lung Problems? | | Yes / No | | | | | |
| Sleep Apnea? | | Yes / No | Yes / No | | | | |
| If yes, CPAP / If yes, how ma | | | ? | | | | |
| Do you have Liver Disease? | | Yes / No | Yes / No | | | | |
| Do you have Kidney Disease? | | Yes / No | Yes / No | | | | |
| Are you a Diabetic? | | Yes / No | Yes / No | | | | |
| If yes, have yo | ou had eye pr | oblems becaus | se of your diabetes? | Yes / No | | | |
| Do you have Glaucoma? | | Yes | Yes / No | | | | |
| Do you have Macular | Degeneratio | n? Yes , | / No | | | | |
| FAMILY HISTORY Do your parents, bro | ther or sisters | s have any of th | ne following? | | | | |
| Diabetes | Yes / No | If yes, who_ | If yes, who | | | | |
| High Blood Pressure | Yes / No | If yes, who_ | If yes, who | | | | |
| Stroke | Yes / No | If yes, who | | | | | |
| | | What age | | | | | |
| Heart Attack | Yes / No | If yes, who_ | If yes, who | | | | |
| | | What age | | | | | |