

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					