Stroke Screen Patient Information and Risk Factor Assessment

Name:____ DOB:____________________ Date: _____________

Address: ____

____

____

SSN:__________________________________ Home Phone #: ____

Primary Care Physician: ____

Address: ____

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Risk Factor Assessment

Do you have High Blood Pressure or take medication to control High Blood Pressure?	Yes	No
Do you now, or used to, smoke or chew tobacco products?	Yes	No
Are you diabetic?	Yes	No
Do you take medication for treatment for high cholesterol?	Yes	No
Do you have a history of vascular disease, stroke or heart attack?	Yes	No
Do you have a family history of vascular disease, stroke or heart attack?	Yes	No
Do you have a history (personal or family) of abdominal aortic aneurysms?	Yes	No
Do you have muscle discomfort, cramping or pain in your legs when you walk a short distance and is relieved if you stop?	Yes	No
Do you have any ulcers or sores on your legs or feet that are slow to heal?	Yes	No
Are you 50 years old or older?	Yes	No
Are you African-American?	Yes	No

Stroke Screening Survey

Is this your first ultrasound wellness screening (Stroke, AAA, PAD) at HMC?	Yes	No
If you have had a screening exam before, has it been at least 5 years ago?	Yes	No

If you answered yes to any of the risk factor questions and you answered yes to one of the stroke screening survey questions, a vascular disease screening test should be considered. You may contact the HMC Vascular Lab Office at 309-449-4226 to schedule the appropriate one time free screening examination(s). While a physician's order is not required you must provide the name of your primary physician so we may provide a copy of the screening report to them.

This is a screening evaluation only and is not intended to be a complete diagnostic study and you are encouraged to discuss any questions you have about your risk factors with your primary physician before scheduling a screening evaluation.

Patient Signature:____Date:_____________