



Langone Medical Center

Vascular and Endovascular Surgery
nyuvascular.com



VASCULAR & STROKE SCREENING INFORMATION SHEET

Patient Name: _____

Address: _____ **City** _____ **State** _____ **Zip Code** _____

Telephone # _____ **Email Address:** _____

Date of Birth: _____ **How did you hear about the screening?** _____

Please answer the following questions:

- 1) Do you have a history of smoking? Yes _____ No _____
- 2) Do you have a history of hypertension? Yes _____ No _____
- 3) Do you have a history of carotid disease? Yes _____ No _____
- 4) Do you have a history of diabetes? Yes _____ No _____
- 5) Do you have a family history of stroke? Yes _____ No _____
- 6) Do you have leg pain when walking? Yes _____ No _____

