



SCREENING QUESTIONNAIRE

Patient Name _____

Date of Birth: _____

1. Did you have COVID-19 or do you think you were exposed?	YES	NO
2. Do you have diabetes?	YES	NO
3. Do you have high blood pressure?	YES	NO
4. Do you have high cholesterol?	YES	NO
5. Do you have sleep apnea?	YES	NO
6. Do you have erectile dysfunction (if applicable)?	YES	NO
7. Do you have chronic kidney disease?	YES	NO
8. Do you have heart disease?	YES	NO
9. Do you smoke or have a history of smoking?	YES	NO
10. Do you ever have pain or numbness in your fingers, hands, toes or feet or do they ever feel cold?	YES	NO
11. Do you ever get pain in your legs when you walk?	YES	NO



I, _____ (*print patient name*), acknowledge that the Medical Assistant has reviewed the results of this screening questionnaire and I understand the purpose for the Cardiovascular Wellness Assessment. I am aware that I may not have met my deductible which may result in a balance due. **[Please initial one of the following statements to indicate consent to the assessment.]**

_____ I **consent** to the test. *or* _____ I **do NOT consent** to the test.

Patient Signature _____

Date: _____

MA Initial: _____