Edited by SL 5/12/20

Pulse 4 Pulse

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. **[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: _____