Upstate Neurology, P.A.

Stroke Risk Questionnaire

1. Do you have high blood pressure? yes_____ no_____

2. Do you have high cholesterol? yes_____ no_____

3. Do you have diabetes? yes_____ no_____

4. Do you smoke cigars or cigarettes? yes_____ no_____

5. Do you have a family history of stroke? yes_____ no_____

6. Are you overwieght? yes_____ no_____

7. Have you ever had a stroke? yes_____ no_____

8. Have you ever experienced temporary numbness, tingling, vision loss, difficulty speaking, walking or severe headaches? yes_____ no_____

Mild _____ (0-2) Moderate _____ (3-5) Severe _____ (6-8)

Name: _____

Address: _____

Phone: _____

Primary Care Physician: _____

Medical Insurance: _____