Cardiovascular Health Survey

Name _____

Phone Number _____Email _____

Address _____

_____

City State ZIP

In our efforts to move towards the prevention of heart disease related issues we would like to provide you with education and a natural method for improving your circulation and cardiovascular health leading to better overall wellness. Please fill out this check list and then return it to the person who gave you this prevention form:

Please Check All That Apply to	***You***	***Family Member***
High Blood Pressure	_____	_____
Diabetes	_____	_____
Cholesterol Concerns	_____	_____
Poor Circulation	_____	_____
Strokes or Family History of Strokes	_____	_____
Heart Attacks or Family History of Heart Attacks	_____	_____
Women's Heart Health	_____	_____
Poor Sexual Health or Erectile Dysfunction	_____	_____
Alzheimer's Disease or Cognitive Impairment	_____	_____

Please circle the <u>one</u> health concern that you would like to receive additional information about:

High Blood Pressure **Diabetes** **Cholesterol Concerns** **Poor Circulation**

Stroke Prevention **Heart Attack Prevention** **Women's Heart Health**

Poor Sexual Health/ED **Alzheimer's Disease/Cognitive Impairment**

Thank you! Please return this survey form to the person who gave it to you!