

# SLRHC Cardiovascular Prevention Program - Cardiovascular Health Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month / day / year

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month / day / year

## Personal History

**Sex :**        \_\_\_\_\_ Male        \_\_\_\_\_ Female

<b>Race:</b>		White		Native American/Alaskan
		African American		Asian/Pacific Islander
		Hispanic (country of origin: _____)		Do Not Know
				Other: _____

<b>Education :</b>		Less than high school graduate		College graduate
		High school graduate or equivalent		Post-graduate/professional degree
		Some post-high school education		Other: _____

**Current Occupation :** \_\_\_\_\_

<b>Marital Status:</b>		Never Married		Widowed
		Married		Divorced
		Living with someone		Separated

If you are married or living with someone, is your partner:        \_\_\_\_\_ same sex        \_\_\_\_\_ opposite sex

<b>Dependants :</b> (how many?)		None		Parents
		Children		Other:
		Spouse		

Who currently lives with you? \_\_\_\_\_

Do you have any pets? \_\_\_\_\_



**Medical History**

**Cardiovascular Disease - please check all that apply**

If "yes", please supply any related medical records, lab results, EKGs or other tests

	Y / N	Date & Location Diagnosed		Y / N	Date & Location Diagnosed
Angina or chest pain due to heart disease			Congestive heart failure		
Heart attack or myocardial infarction			Irregular heart rhythm (atrial fibrillation)		
Clot in lung/s or leg veins			Congenital heart defect		
			Coronary artery bypass surgery		
Blocked arteries in the neck (carotid) or brain			Coronary angioplasty or stent placement		
			Carotid or peripheral bypass surgery / CEA		
Blocked arteries in the legs			Artificial pacemaker or defibrillator		
			Abdominal aneurysm		
Valvular heart disease stenosis/regurgitation			Aortic aneurysm		
Valve surgery (which valve?)					
Stroke					

**Other Disease - please check all that apply**

If "yes", please supply any related medical records, lab results, EKGs or other tests

	Yes / No / Maybe		Yes / No / Maybe
Thyroid disease		Pancreatitis	
Kidney disease (urinary infections)		Psychiatric disease (depression, anxiety)	
Bowel disease (colitis, diverticulitis or irritable colon, GI bleeding)		Arthritis (joint pain)	
		Rheumatoid arthritis	
Gallbladder disease		Gout	
Neurologic disease (muscle or nerves)		Glaucoma	
		Cataract	
Lung disease (emphysema, bronchitis, or asthma)		Skin problems	
		Blood disorders / Anemia	
Liver disease (cirrhosis, hepatitis)		Thrombophlebitis	
		Blood clotting disorder	
Peptic ulcer disease		Rheumatic fever	
Alcoholism		Other:	
Cancer (specify type)		Other:	

**Surgical History & Previous Hospitalizations**

Operation / Hospitalization (please specify)	Hospital (specify)	Date (month / year)
		/
		/
		/

**Cardiovascular Risk Factors**

**Cholesterol:**

**Yes**

**No**

Have you ever been told your blood cholesterol or triglycerides are abnormal? \_\_\_\_\_

- If yes, when? \_\_\_\_\_

Have you ever seen a registered dietician? \_\_\_\_\_

Are you currently being treated for abnormal cholesterol with diet therapy? \_\_\_\_\_

Are you currently being treated for abnormal cholesterol with medication? \_\_\_\_\_

What is your highest cholesterol reading to date? \_\_\_\_\_

**Hypertension:**

**Yes**

**No**

Has a health professional ever told you that you have high blood pressure or hypertension? \_\_\_\_\_

If yes, have you ever been treated with medication for high blood pressure? \_\_\_\_\_

Are you currently being treated for high blood pressure with medication? \_\_\_\_\_

How long have you had high blood pressure? \_\_\_\_\_ years or \_\_\_\_\_ less than one year

**Diabetes:**

**Yes**

**No**

Has a health professional ever told you that you have diabetes mellitus or sugar diabetes? \_\_\_\_\_

If yes, do you take insulin injections to control your diabetes? \_\_\_\_\_

Do you take other medications to control your diabetes? \_\_\_\_\_

How long have you had diabetes? \_\_\_\_\_ years or \_\_\_\_\_ less than one year

**Smoking History:**

Do you currently smoke cigarettes?     Yes                       No

If no, did you ever smoke?             Yes                       No (skip to "second-hand smoke")

***If you currently smoke:***

How many years have you smoked?    \_\_\_\_\_

On average, how many cigarettes/day? \_\_\_\_\_

Have you ever tried to quit?     Yes                       No

If you have tried to quit, how many times?    \_\_\_\_\_

How have you tried?

***If you used to smoke:***

How many years did you smoke?    \_\_\_\_\_

On average, how many cigarettes/day? \_\_\_\_\_

How long ago did you quit?

\_\_\_\_\_ < 6 months ago                      \_\_\_\_\_ 6 months - 2 years

\_\_\_\_\_ 2 - 10 years                      \_\_\_\_\_ over 10 years ago

**Second-Hand Smoke:**

How often are you exposed to second-hand smoke?    \_\_\_\_\_ hours / minutes (*circle one*) per day / week (*circle one*)

Where are you exposed?     Home                       Work                       Social

**Physical Activity:**

How physically demanding is your usual daily activity (job, schoolwork, housework, etc.)?

\_\_\_\_\_ Not at all                      \_\_\_\_\_ Moderately                      \_\_\_\_\_ Very

How many miles do you walk each day? (In NYC, 20 blocks = 1 mile)                      \_\_\_\_\_

At least once a week, do you engage in any regular physical activity (brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, how many times per week?    \_\_\_\_\_                      For how many minutes?    \_\_\_\_\_

During which seasons do you exercise?    \_\_\_\_\_ Winter                      \_\_\_\_\_ Spring                      \_\_\_\_\_ Summer                      \_\_\_\_\_ Fall

Briefly describe your exercise regimen:

**Dietary Factors:**

Current height: _____ ft. _____ in.	Weight at age 18 _____ lbs.
Current weight: _____ lbs.	Highest adult weight _____ lbs. (not including pregnancy)

Are you following any special diet? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which of the following: *(please check all that apply)*

<input type="checkbox"/>	Low fat diet	<input type="checkbox"/>	Low cholesterol diet
<input type="checkbox"/>	Low salt / low sodium diet	<input type="checkbox"/>	Weight reduction diet
<input type="checkbox"/>	Vegetarian diet	<input type="checkbox"/>	Diabetic diet
<input type="checkbox"/>	Atkins Diet	<input type="checkbox"/>	Slim Fast
<input type="checkbox"/>	The Zone	<input type="checkbox"/>	Weight Watchers
<input type="checkbox"/>	South Beach Diet	<input type="checkbox"/>	Jenny Craig
<input type="checkbox"/>	other:	<input type="checkbox"/>	do not know:

Do you drink alcoholic beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please specify number of drinks per week:

Wine, sherry, port (1 drink = 4 oz.)	_____ drinks/wk	Beer, ale, etc. (1 drink = 12 oz.)	_____ drinks/wk	Spirits or hard liquor (1 drink = 1.5 oz.)	_____ drinks/wk
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How many years have you been drinking these amounts? \_\_\_\_\_ years

Did you ever consider yourself a heavy drinker? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you take any nutritional supplements? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which of the following: *(please check all that apply)*

<input type="checkbox"/>	Multivitamin	<input type="checkbox"/>	Beta carotene	<input type="checkbox"/>	Ginseng
<input type="checkbox"/>	Multivitamin with minerals	<input type="checkbox"/>	Combination antioxidant	<input type="checkbox"/>	Garlic
<input type="checkbox"/>	Calcium	<input type="checkbox"/>	Vitamin E	<input type="checkbox"/>	other:
<input type="checkbox"/>	Vitamin C	<input type="checkbox"/>	Folic acid	<input type="checkbox"/>	other:
<input type="checkbox"/>	Iron	<input type="checkbox"/>	Selenium	<input type="checkbox"/>	other:

Do you drink coffee regularly?      \_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, how many cups (6 oz.) per day?      \_\_\_\_\_ cups/day

What type of coffee do you usually drink?      \_\_\_\_\_ Regular                      \_\_\_\_\_ Decaffeinated                      \_\_\_\_\_ Both

Do you take aspirin regularly?      \_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, which type?      \_\_\_\_\_ Adult (325 mg.)      \_\_\_\_\_ Baby (81 mg.)      \_\_\_\_\_ Other: \_\_\_\_\_

How many tablets per week?      \_\_\_\_\_ tablets/week

**Stress and Emotional Health:**

On a scale of 1-10, with 1 being no stress at all, and 10 being the most stressed, how do you rate the following:

	1	2	3	4	5	6	7	8	9	10
Stress level at work:										
Stress level at home:										
Overall stress level:										

*The following questions are used to screen for depression, which is commonly diagnosed in patients with heart disease.*

How confident do you feel in managing your stress?

\_\_\_\_\_ not confident      \_\_\_\_\_ somewhat confident      \_\_\_\_\_ fairly confident                      \_\_\_\_\_ very confident

	<u>Yes</u>	<u>No</u>
In the past month, have you felt depressed or unhappy most of the day, more days than not?	_____	_____
In the last six months, have you felt particularly anxious more days than not?	_____	_____
During the last month, have you been less interested in most things or unable to enjoy the things you used to do?	_____	_____
Have you been bothered by attacks of anxiety, trembling or shaking, or rapid heart rate?	_____	_____
Have you had any changes in your sleep pattern?	_____	_____

If yes, please describe:

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**Provider Section**

**HEALTH QUESTIONNAIRE SUMMARY**

Name:

Date of Birth:

Today's Date:

Provider:

Age

Sex

History of present illness / Reason for program visit

Risk Factors

Pertinent lab / Testing

Other notes

"I have reviewed the information contained in the entire questionnaire and have reviewed the pertinent findings with the patient. Key findings are summarized in the progress note; the questionnaire may be referenced for additional details."

Provider signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Follow-Up Notes***

Name:

Date of Birth:

Today's Date:

Provider:

"My signature below indicates that I have re-reviewed the questionnaire with the patient and noted any changes (summarized in the progress note). Questionnaire was initially completed in the current calendar year."

Provider signature: \_\_\_\_\_

Date: \_\_\_\_\_