

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

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

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

Current Occupation : _____

Marital Status:	Never Married		Widowed
	Married		Divorced
	Living with someone		Separated

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

Dependants : (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:

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: _____