

Preventive Cardiology ♥ New Visit Questionnaire

Please complete and return

Name _____ Date of Birth _____

♥ **Do you have any symptoms or specific issues you'd like to discuss today?** Yes No

If yes, please describe:

♥ **Physical Activity:**

* Usual activity : _____ Sessions per week: _____

Minutes per session: _____

* Over the past several years, has your **physical activity level**:

Decreased Stayed the same Increased

* Do you have leg pain when walking that goes away when you rest? Yes No

♥ **Weight:** Over the past several years, has **your weight**:

Decreased Stayed the same Increased If changed, what accounts for this?

♥ **Smoking:** Are you smoking? Yes No If yes, how many packs per day? _____

♥ **Blood Pressure:** Do you check your **blood pressure (BP) at home?** Yes No

If yes, what is the typical range?

Systolic BP (top #) _____ Diastolic BP (lower #) _____

♥ **Cholesterol:** Have you ever been told you have high cholesterol? Yes No

If yes write in #s: Total cholesterol _____ Triglycerides _____

HDL _____ LDL _____

♥ **Stress:** How would you rate your overall **stress level**?

Very low Low Moderate High Very high

♥ **Menopause:** Have you gone through **menopause**? Yes No

If yes, at what age? _____

Have you had a hysterectomy? Yes No

Are you taking hormone therapy? Yes No

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♥**Polycystic Ovary Syndrome:** Do you have polycystic ovary syndrome? Yes No

♥**Diabetes:** Do you have diabetes? Yes No

If yes, Type I or Type II? _____

What have your fasting home readings been? Typical fasting glucose _____

Have you been told that you are at risk for developing diabetes or have impaired fasting glucose levels (pre-diabetic)? Yes No

♥**Family History: Do you have family history of coronary heart disease?** Yes No

If yes, who and at what age? _____

♥**Depression screen: In the last 2 weeks, how often have you-**

- Felt down, depressed or hopeless? not at all several days more than half the days every day
- Had little interest or pleasure in doing things? not at all several days more than half the days every day

♥**Medications:** Are you taking the following medications?

Aspirin: Yes No

Statin (for cholesterol): Yes No

Blood pressure medication: Yes No

♥**Heart disease risk:**

Have you ever discussed your heart disease risk with your health care provider?

Yes No

What do you think your risk of heart disease is? Low Moderate High

♥**Health care provider information:**

Do you have a primary care physician? Yes No

If yes, please provide their name _____

If no, do you see your OBGYN only? Yes No

If yes, please provide their name _____