

CARDIAC RISK ASSESSMENT

Name \_\_\_\_\_  
What would you like to be called by the Doctor \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Medications now being taken \_\_\_\_\_  
Allergies or Drug reactions (Specify Drug and Reaction)  
\_\_\_\_\_

Risk Modification

Do you eat foods low in fat and cholesterol? \_\_\_\_\_  
Do you exercise regularly? \_\_\_\_\_  
Past medical History (Please include all hospitalizations, surgeries, and major illnesses) \_\_\_\_\_  
\_\_\_\_\_

Cardiovascular Risk Factors

Have you had your cholesterol checked recently? \_\_\_\_\_  
Date of test \_\_\_\_\_ Total cholesterol \_\_\_\_\_  
HDL \_\_\_\_\_ LDL \_\_\_\_\_ Triglycerides \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Former smoker \_\_\_\_\_ Quit date \_\_\_\_\_  
Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ Number of drinks per week? \_\_\_\_\_  
Do you have: Diabetes? \_\_\_\_\_ How long? \_\_\_\_\_  
High Blood Pressure? \_\_\_\_\_ How long? \_\_\_\_\_  
History of heart attack, angina, bypass surgery, angioplasty, stroke, TIA, or claudication (pain in legs when walking)? \_\_\_\_\_

Family History of Heart Disease prior to Age 55

Do you have a family history of early Heart Disease and or high cholesterol in parents or siblings? \_\_\_\_\_

For Women

Have you been through menopause? \_\_\_\_\_ What age? \_\_\_\_\_  
Have you had a hysterectomy? \_\_\_\_\_ What age? \_\_\_\_\_  
Are you on estrogen replacement? \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE