

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