

Name: _____

DOB: _____ MRN: _____

Age: _____ Date: _____

Preventive Cardiology

New Visit Questionnaire

Please complete and return to your healthcare provider

Do you have any symptoms or specific issues you'd like to discuss today? Yes No If yes, please describe: _____

Physical Activity:

Usual activity #1: _____ Sessions per week: _____ Minutes per session: _____

Usual activity #2: _____ Sessions per week: _____ Minutes per session: _____

Other Physical activity: _____

Over the past several years, has your **physical activity level**: Decreased Stayed the same Increased

Dietary Practices:

How many servings of **vegetables** do you eat per day? (1 serving = 1/2 cup cooked) _____

How many servings of **fruit** do you eat per day? (1 serving = medium apple) _____

How many servings of **whole grains** (brown rice, oatmeal) per day? (1 serving = 1/2 cup cooked) _____

How many servings of **fish** per week? (1 serving = 1/4 pound) _____

How many servings of **poultry (chicken or turkey)** per week? (1 serving = 1/4 pound) _____

How many servings of **red meat** per week? (1 serving = 1/4 pound) _____

Over the past several years, have **your food choices** become: Better No different Worse

If different, in what ways? _____

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 cigarettes 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

Have you ever taken medicine for high cholesterol? If so, what? _____

Stress: How would you rate your overall **stress level**? Very low Low Moderate High Very high

Mood: During the past month, have you often been bothered by:

Feeling down, depressed, or hopeless? Yes No

Little interest or pleasure in doing things? Yes No

If female: Have you gone through **menopause**? Yes No If yes, at what age? _____

Have you had a hysterectomy? Yes No Have you taken hormone therapy? Yes No

Diabetes: If you have **diabetes**, please complete the questions on the other side of this page

Checklist for patients with Diabetes:

Home glucose monitoring: Do you check your **blood sugar** regularly at home? Yes No

If yes, what have your fasting readings been since your last visit?

Highest fasting glucose _____ Lowest fasting glucose _____ Typical fasting glucose _____

American Diabetes Association (ADA) Recommended Annual Examinations:

Have you had the following examinations during the last year?

Eye exam in the last year? Yes No Any problems noted? _____

Dental exam in the last year? Yes No Any problems noted? _____

Foot exam in the last year? Yes No Any problems noted? _____

ADA Recommended Medications: Are you taking the following medications?

If you don't know, please ask your health care provider:

Aspirin or similar drugs: Yes No

Statin (for cholesterol): Yes No

ACE inhibitor or ARB: Yes No
(for blood pressure)



Once you complete this form, please give it to your healthcare provider for review during this appointment.