Cardiovascular Risk Assessment Questionnaire

Please fill out this questionnaire to help assess your cardiovascular health and risk factors. This document is designed to be printed and completed by hand or typed.

1. Patient Information

Full Name:

Date of Birth (MM/DD/YYYY):

Biological Sex (Male / Female):

Today's Date:

2. Biometric and Clinical Measurements (If known)

Height (feet/inches or cm):

Weight (pounds or kg):

Most Recent Blood Pressure (e.g., 120/80):

Total Cholesterol level (mg/dL):

HDL ("Good") Cholesterol level (mg/dL):

LDL ("Bad") Cholesterol level (mg/dL):

3. Personal Medical History

Please write "Yes" or "No" for each condition below:

Have you been diagnosed with High Blood Pressure?

Have you been diagnosed with Diabetes?

Have you been diagnosed with High Cholesterol?

Have you ever had a Heart Attack, Stroke, or TIA?

Do you have Chronic Kidney Disease?

4. Lifestyle and Habits

Do you currently smoke cigarettes or use tobacco products? (Yes / No):

If you are a former smoker, how many years ago did you quit?:

On average, how many minutes of moderate exercise do you get per week?:

How many alcoholic drinks do you consume in an average week?:

5. Family Medical History

Did any immediate family member (parents, siblings) have a heart attack or stroke before age 55 (for males) or age 65 (for females)? (Yes / No):

If yes, please list their relationship to you:

6. Current Symptoms

Please write "Yes" or "No" if you regularly experience any of the following:

Chest pain, tightness, or pressure during physical exertion:

Unexplained shortness of breath:

Dizziness, lightheadedness, or fainting spells:

Heart palpitations (fluttering, skipping beats, or racing heart):