Enrollment Questionnaire

Name________________________________ Date:_____________________
SSN:________________________________ Date of Birth:_______________
Occupation:____

MEDICAL HISTORY

1. Do you take any medications on a regular basis? ❒ Yes ❒ No
   Please include over the counter supplements.

	Medication	***Dose (mg)***	***Frequency***	***Start Date***
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

2. Have you ever taken medication to improve your cholesterol level? ❒ Yes ❒ No
   *If yes, which one(s)*____

3. Do you have any medication allergies ❒ Yes ❒ No
   If yes, please list them with type of reaction:_____________________________
   ____
   ____

4. Please indicate whether or not you have or have been treated for any of the following conditions/procedures:

High Cholesterol	❒ Yes	❒ No
High Triglycerides	❒ Yes	❒ No
High Blood Pressure (Hypertension)	❒ Yes	❒ No
Coronary Artery Disease	❒ Yes	❒ No
Heart Attack (Date:____________)	❒ Yes	❒ No
Bypass Surgery (Date:____________)	❒ Yes	❒ No
Angioplasty or Stent (Date:____________)	❒ Yes	❒ No
Stress Test (Date:____________)	❒ Yes	❒ No
Angiogram	❒ Yes	❒ No
Ultra Fast CT Scan of the heart	❒ Yes	❒ No
Peripheral Arterial Disease	❒ Yes	❒ No
Stroke	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No
Thyroid disease or problem	❒ Yes	❒ No
Kidney disease	❒ Yes	❒ No
Liver disease or jaundice	❒ Yes	❒ No
Asthma	❒ Yes	❒ No
Emphysema or other lung disease	❒ Yes	❒ No

5. In the past 6 months, have you experienced any of the following symptoms?

Weight loss or gain	❒ Yes	❒ No
Shortness of breath	❒ Yes	❒ No
Chest pain	❒ Yes	❒ No
Shoulder or back pain	❒ Yes	❒ No
Dizziness or lightheadedness	❒ Yes	❒ No
Excessive thirst	❒ Yes	❒ No
Frequent urination	❒ Yes	❒ No
Leg cramps/pain with walking	❒ Yes	❒ No

6. Have you had a hysterectomy? ❒ Yes ❒ No
Are you post-menopausal? ❒ Yes ❒ No
Do you take any hormone supplements? ❒ Yes ❒ No
Do you suffer from depression ❒ Yes ❒ No

7. Are you a smoker? ❒ Yes ❒ No ❒ Ex
If yes or ex: How much do (or did) you smoke per day?______________________________
How long have (or had) you been smoking?______________________________
How long ago did you quit smoking?______________________________

8. Has your **father** had any of the following conditions?

Stroke	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Heart Attack	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Bypass Surgery	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Angioplasty	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Coronary Artery Disease		❒ Yes	❒ No	❒ Not sure

9. Has your **mother** had any of the following conditions?

Stroke	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Heart Attack	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Bypass Surgery	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Angioplasty	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Coronary Artery Disease		❒ Yes	❒ No	❒ Not sure

10. Has your **brother** or **sister** had any of the following conditions?

Stroke	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Heart Attack	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Bypass Surgery	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Angioplasty	(approximate age__________)	❒ Yes	❒ No	❒ Not sure
Coronary Artery Disease		❒ Yes	❒ No	❒ Not sure

11. Describe the type and amount of exercise you do regularly:______________________________
____

Any restrictions?______________________________
____

NUTRITION INFORMATION

12. What is your current weight? ____________ lbs.
    What do you consider your ideal weight? ____________ lbs.

13. Have you ever seen a Dietitian? ____________
    Who usually prepares the food? ____________
    Who does the food shopping? ____________
    Does the shopper read food labels? ____________
    Do you read food labels? ____________
    Have you ever calculated % fat in your diet or counted fat grams? ____________

14. List one typical day of eating & drinking: (*include amounts and types: regular, low fat, fat free)*

Breakfast	Lunch	Dinner	Snacks

15. Do you drink alcoholic beverages? ❒ Yes ❒ No
    If yes, how many ounces do you average per week: ____________ oz. liquor
    ____________ oz. wine
    ____________ oz. beer

16. Are there any things that you do or that you eat that you believe may be contributing to any health problems?
    ____
    ____
    ____

I understand that my enrollment in the **Central Minnesota Heart Center's Women's Cardiac Health Program** includes my authorization for the release of information regarding my results to my family physician.

____________________ ____________________
(signature) (date)

Primary/family physician information:

Name of M.D.____________
Clinic: ____________
Address____________
City____________ State:________ Zip:____________
Phone:____________ FAX:____________