

CARDIOVASCULAR RISK ASSESSMENT SHEET

PRACTICE NAME _____ Date _____
 Patient Name _____ DOB/Age _____ Phone _____
 Occupation _____ Referred By _____

Chief Complaint/Reason for Evaluation:

HISTORY OF PRESENT ILLNESS	Risk Factors For CAD
	Fam Hx _____
	Smoking:Pks/Yrs _____
	Quit _____
	Dyslipidemia _____
	DM _____
	HTN _____
	ETOH _____
	Inactivity _____
	Stress _____
	Weight _____
	Other _____

Women Only

Pregnant () Yes () No: Planning Pregnancy () Yes () No: G__P__ Postmenopause () Yes () No

PAST MEDICAL / SURGICAL HISTORY

Hospitalization or Surgery	Current Medications
Reason _____ Date _____	
	Allergies

Medical History

Review of Symptoms

Cardiovascular	() CAD	() Cardiomyopathy	() Valvular Dz	Wt chg
	() CHF	() Arrhythmia	() RHD	Dyspnea
Respiratory	() COPD	() Pulm Embolism	() Cough	Chest Pain
GI/GU	() PUD	() Hepatitis	() Prostate	Peripheral Edema
Renal/Endo	() Renal Failure	() Thyroid		Abdomen
Periph Vasc	() Carotid ASO	() AAA	() Claudication	Numbness ext
Neurological	() CVA/TIA	() Seizure	() Migraine HA	Freq UTI
Heme/On.	() Anemia	() Cancer		Mental Health

FAMILY HX	Alive/Well	Deceased	HTN	CAD	Stroke	PVD	Diabetes	Age/Cause of Death
Father	()	()	()	()	()	()	()	_____
Mother	()	()	()	()	()	()	()	_____
Siblings	()	()	()	()	()	()	()	_____
	()	()	()	()	()	()	()	_____