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	( )	( )	( )	( )	( )	( )	( )	
	( )	( )	( )	( )	( )	( )	( )	