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LIPIDS CLINIC

Mobile Health Team Adult Enrollment Questionnaire

Thank you for completing this form before your visit. When you come in for your initial appointment we will go over the history together. Leave blank any questions with which you are not familiar.

Name_____ **Date**_____

Date of Birth_____ **Primary Care Provider:**_____

MEDICAL HISTORY Please check if in the past you have had any of the following.

	Coronary Artery Disease		High Cholesterol		Asthma
	Heart Attacks		Diabetes (Type I or II)		COPD
	Heart Valve Problem		Pre-Diabetes		Arthritis
	Congestive Heart Failure		Thyroid Problems		Memory Problems
	High Blood Pressure		Gout		Sudden Vision Loss
	Rheumatic Heart Disease		Bowel (Intestine) Problems		Depression
	Blood clotting Problems		Stomach Problems		Anxiety or Panic Attacks
	Peripheral Artery Disease		Gastric Reflux		Cancer or Tumors
	Carotid Artery Disease		Stomach/Peptic Ulcers		Kidney Problems
	Stroke or Mini Stroke		Gall Bladder Problems		Seizures and/or Epilepsy
	Aneurysm		Liver Problems		Other:

Other:_____

SURGICAL HISTORY

Please check if in the past you have had any of the following. In the space below list date of events.

	Bypass Surgery (CABG)		Coronary Calcium Score		Pacemaker
	Angiogram (Heart Cath)		Stress Test/Treadmill		EP Study of Heart
	Stent of Heart Artery		Echocardiogram		Carotid Artery Studies

Other Surgeries and Dates:_____

Please check if you have any of the following RECENT OR NEW CONCERNS: None_____

	Recent Weight Changes		Heartburn or Indigestion		Yellow spots or rashes on skin
	Severe Fatigue		Weakness		Intolerance to Cold or Heat
	Palpitations		Easy Bruising or Bleeding		Nausea, Vomiting or Diarrhea
	Chest Pain		Hair Loss on Legs		(*Men)* Erectile Dysfunction
	Wheezing		Problems with Urination		(*Women)* Irregular Periods
	Shortness of Breath		High or Low Blood Sugar		Joint Pains or Muscle Pains
	Abdominal Pain		General Loss of Interest		Leg Cramps
	Constipation		Depression or Anxiety		Seizures and/or Epilepsy

Women: Are you currently or possibly pregnant? ____Yes ____No

Women: Are you currently or possibly post-menopausal? ____Yes ____No

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CURRENT MEDICATIONS:

Prescriptions:_____

_____

_____

Over the counter/Herbal/Supplements: _____

Cholesterol Medications you have tried (if any): _____

ALLERGIES:

Have you had medication allergies or severe side effects? If yes, please list them with types of reactions:

_____

Food, Environmental, Herbal/Supplements Allergies:_____

FAMILY HISTORY List history of family members with these problems & ages at onset:

High Blood Pressure_____ Coronary Artery Disease_____

High Cholesterol_____ Bypass Surgery_____

Diabetes_____ Heart Attacks_____

Strokes_____ Other_____

Heritage: (We ask this because certain genetic cholesterol and/or heart problems may occur in certain ethnic/racial groups.) Check all that apply: ___Dutch ___South African ___Asian ___Hispanic ___French Canadian ___Jewish ____African American ___Other (please list) _____

SIBLINGS: #Brothers _____ # Sisters _____

CHILDREN: # Sons _____ Ages_____ ; # Daughters _____ Ages _____

SOCIAL HISTORY:

Are you (please circle): Married Single Partnered Divorced Widowed

Do you work outside the home? ____Yes ____No Occupation:_____

Do you use tobacco? ____Yes ____No ___Quit (Date_____) If yes, what and how much?_____

HEALTHY LIVING

Do you have any limitations to exercise? ____Yes ____No If yes, what limits you? _____

What types of exercise do you do? _____ How many days per week? _____

Please list one typical day of eating: (include amounts and types of foods – reg, low-fat, fat-free, etc) ?

Breakfast_____

Lunch_____

Dinner_____

Have you ever seen a Dietitian or Nutritionist? ____Yes ____No

Do you prepare the food? ____Yes ____No

Do you read food labels? ____Yes ____No Who does the food shopping? _____

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How many times **a day** do you:

Eat Fruits ____1 _____ 2 _____3 _____4 _____5 or more

Eat Vegetables ____1 _____ 2 _____3 _____4 _____5 or more

Eat Whole Grains (whole grain breads or tortillas, brown rice, oatmeal, pasta) ___1 ___ 2 ____ 3 or more

Drink Water (Glass or Bottles **per DAY**) ____1 _____ 2 _____3 _____4 _____5 or more

Eat Desserts/Sugary Foods ____< 1 _____ 1 _____ 2 _____3 _____4 _____5 or more

Drink Glasses Milk (Type: __2% __1% __skim) ____< 1 _____ 1 _____ 2 _____3 _____4 ____5+

Drink Sugary Beverages (soda, pop, juice, Gatorade, Capri Sun, etc.) ____< 1 _____ 1 _____ 2 _____3+

Drink caffeine ____< 1 _____ 1 _____ 2 _____3 _____4 _____5 or more

Spend hours on Screens (weekdays) _____ 1-2 _____ 3-4 _____5 or more

Spend hours on Screens (weekend days) _____ 1-2 _____ 3-4 _____5 or more

How many times **a week** do you:

Eat Lean Protein (fish, chicken, turkey, tofu, beans, eggs, etc) ___1 ___ 2 ____ 3 ___4 ____5 or more

Get 60 minutes of active play or exercise ____1 day _____ 2days _____3 _____4 _____5 or more

Eat fast food or eat out at a restaurant __1 time ___ 2 times ____ 3 _____4 _____5 or more

Skip Meals __1 time ___ 2 times ____ 3 _____4 _____5 or more

Which meal is missed most commonly: _____Breakfast _____ Lunch _____Dinner

MAKING CHANGES

Do you think you need to make changes in your nutrition and/or activity: ____Yes ____No

Is now a good time for you to make change? ____Yes ____No

On a scale of 1 to 5 (1 = confident, 5 = not at all confident), rate your confidence for making changes: __

Please check all the options you think could use improvement:

	More Fruits		Healthier Snacks		More Grains/Fiber
	More Vegetables		Smaller Portion Sizes		More Exercise
	Not Skipping Meals		Fewer Fats		Less Sitting
	Fewer Sugary Drinks		Less Sugar and/or Carbs		Other:

What would you like to be sure we cover during your visit with us? (Examples might include Education on a topic, Medication, Nutrition or Exercise help, Reassurance, etc. or specific questions.)

_____

_____

Thank you for taking the time to fill out this form. We look forward to meeting you!