



THE ROGOSIN INSTITUTE
Centers For Medical Research And Health Care

**Comprehensive Lipid Control Center
Patient History Form**

This is a confidential record, and information contained within will not be released except when you have authorized us to do so.

NAME: (Last) _____ (First) _____ (Middle Initial) _____

ADDRESS: (Street & Number) _____

(City) _____ (State) _____ (Zip Code) _____ (Apt. No.) _____

PHONE: (Home/Cell Phone) _____ (Business Phone) _____ **BIRTH DATE:** _____

SEX: ___ M ___ F **MARITAL STATUS:** _____ **OCCUPATION:** _____

FAMILY OR REFERRING PHYSICIAN: _____

ADDRESS: _____ **PHONE:** _____ **FAX:** _____

Do you know of any "blood" relative(s) who or had (indicate relationship in available space):

___ High Cholesterol: _____	___ Angina/Heart Attack: _____
___ High Triglycerides: _____	___ Heart Surgery: _____
___ Diabetes: _____	___ Peripheral Vascular Disease: _____
___ High Blood Pressure: _____	___ Obesity: _____
___ Stroke: _____	

PERSONAL HABITS:

___ YES ___ NO **Do you, or have you regularly smoked? ___ Cigarettes ___ Pipe ___ Cigars**
 How many per day? _____ For how many years? _____ Quit: _____ (year)

___ YES ___ NO **Do you regularly drink wine or liquor? Approximate ounces per day: _____**

___ YES ___ NO **Do you regularly drink beer? Approximate number of bottles per day: _____**

___ YES ___ NO **Do you exercise regularly?**
 TYPE: _____ FREQUENCY: _____
 TYPE: _____ FREQUENCY: _____
 TYPE: _____ FREQUENCY: _____

MEDICATIONS and DIET:

Have you ever been instructed in an American Heart Association, or any other Cholesterol Lowering Diet by a physician, dietician or other dietary professional? ___ YES ___ NO

Are you currently following such a diet? ___ YES ___ NO

Do you know the cholesterol, fat, and saturated fat content of your diet? ___ YES ___ NO

PATIENT NAME: _____

Indicate any medication to lower Cholesterol that you are taking, or have taken in the past?

MEDICATION	DAILY DOSAGE	SIDE EFFECTS	APPOINTMENT DATES

List any other prescription medications that you are currently taking, as indicated:
(Check here ___ if additional medication(s) are listed on back of this page).

MEDICATION	TIMES PER DAY	DOSE	MEDICATION	TIMES PER DAY	DOSE

In addition, are you presently taking, or have you ever taken any of the following over the counter medications for a period of one month or greater?

- | | | | |
|--|---|--|-----------------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Aspirin | <input type="checkbox"/> YES <input type="checkbox"/> NO | Weight reducing pills |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Advil or related | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hormones, estrogens |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Antacids | <input type="checkbox"/> YES <input type="checkbox"/> NO | Fish Oil |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Calcium | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Other medicines, or vitamins, supplements not mentioned _____ | | |

List illnesses, injuries, accidents, hospitalizations, etc. (include year) _____ NONE

To be answered by WOMEN only:

- | | |
|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you still having regular monthly menstrual periods? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you interested in having (any/or additional) children? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you now or have you ever taken birth control pill? WHEN: _____ |

PATIENT NAME: _____

To be answered by both MEN and WOMEN:

- YES NO **Have you ever had pain, tightness, or discomfort in the chest?**
- YES NO **Have you ever had shortness of breath?**
- YES NO **Do you have palpitations?**
- YES NO **Have you ever had dizzy spells?**
- YES NO **Have you ever fainted?**
- YES NO **Do you frequently have severe headaches?**
- YES NO **Have you ever had weakness in an arm or leg?**
- YES NO **Have you ever had double vision?**
- YES NO **Have you ever had a convulsion?**
- YES NO **Do you, or have you ever had pains in calves or legs when walking?**
- YES NO **Do you, or have you ever had cramps in your legs at night?**
- YES NO **Do you, or have you ever had pain in your big toe and/or gout?**
- YES NO **Do you have any history for thyroid disease?**
- YES NO **Do you have any history for diabetes or elevated blood sugar?**

Have you ever had:

Stress Test (list type, date, results): _____

Angiogram (list type, date, results): _____

Ultrafast CT scan (list type, date, results):

Describe briefly why you have come to the Lipid Center?

Please list your most recent lipid results and date:

Date: _____ **Total Cholesterol:** _____ **LDL:** _____ **HDL:** _____ **Triglycerides:** _____
