William Cromwell, MD, FAHA, FNLA
Lipoprotein and Metabolic Disorders Institute, PLLC

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(First, M.I., Last):* ☐ M ☐ F	**Date of Birth (mm/dd/yyyy):**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Referring Physician:	**Primary Care Provider:**
Email:	**Date:**

PERSONAL HEALTH HISTORY – Lipid / Lipoprotein Disorders

When did you first find out that your cholesterol or triglyceride levels were abnormal? _____

Which of the following were abnormal at that time (list actual numbers if you know them, otherwise put "X" to indicate abnormal)

_____ Total Cholesterol _____ Triglyceride _____ HDL ("good") cholesterol _____ LDL ("bad") cholesterol

Other lipid or lipoprotein test results: _____

What recommendations did you receive when this problem was first identified?

Diet (please describe): _____

Exercise (please describe): _____

Medication (name and dosage) : _____

Other (please describe) : _____

Please describe your current diet: _____

Please describe your current exercise: _____

Have any "advanced" lipid tests (NMR, LipoMed, Berkeley, VAP) been performed? ☐ Yes ☐ No Date: _____

When was your last lipid or lipoprotein test? _____ Who ordered this test? _____

Please list history of all cholesterol or triglyceride medications (including current) you have taken:

Medication Name	Strength (mg) and Dosage (times/day)	Date Started	Date Stopped	Why Stopped (list any problems with medicine)

PERSONAL HEALTH HISTORY – High Blood Pressure

Have you been told that you have high blood pressure? ☐ Yes ☐ No Date informed: _____

Check which of the following best describes your blood pressure problem?

☐ "Borderline" Elevation ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Other (Describe): _____

What recommendations did you receive when this problem was first identified?

Diet / Exercise (please describe): _____

Medication (name and dosage) : _____

Other (please (please describe) : _____

Please list history of all blood pressure medications (including current) you have taken:

Medication Name	Strength (mg) and Dosage (times/day)	Date Started	Date Stopped	Why Stopped (list any problems with medicine)

Do you monitor your blood pressure ? ☐ Yes ☐ No If yes, what is your usual reading: _____

PERSONAL HEALTH HISTORY – High Blood Sugar

Have you been told that you have high blood Sugar? ☐ Yes ☐ No Date informed: _____

Check which of the following best describes your blood sugar problem?

☐ "Borderline" Elevation ☐ Diabetes ☐ Low Blood Sugar ☐ Other (Describe): _____

What recommendations did you receive when this problem was first identified?

Diet / Exercise (please describe): _____

Medication (name and dosage) : _____

Other (please (please describe) : _____

Please list history of all blood sugar medications (including current) you have taken:

Medication Name	Strength (mg) and Dosage (times/day)	Date Started	Date Stopped	Why Stopped (list any problems with medicine)

Do you monitor your blood sugar? ☐ Yes ☐ No If yes, what is your usual reading: _____

PERSONAL HEALTH HISTORY – Cardiovascular

Have you ever had any of the following cardiovascular conditions? Explain yes answers in the space below.

	Yes	No	Describe
Known Heart Blockage	☐	☐	
History of Heart Attack	☐	☐	
History of Bypass Surgery	☐	☐	
Blockage in Neck (Carotid) Arteries	☐	☐	
Blockage in Other Arteries	☐	☐	
Abdominal Aortic Aneurysm	☐	☐	
Angioplasty or Stent – Heart Arteries	☐	☐	
Angioplasty or Stent - Other Arteries	☐	☐	
Neck Artery (Carotid) Surgery	☐	☐	
Atrial Fibrillation	☐	☐	
Other Abnormal Heart Rhythm	☐	☐	
Enlarged Heart	☐	☐	
Heart Valve Problems	☐	☐	
Heart Murmur	☐	☐	
Blockage in the Veins of the Legs	☐	☐	

Please list the date and results of the most recent cardiovascular tests listed below:

	Test Performed		Date	Were Results Abnormal		Describe Abnormal Results
	Yes	No		Yes	No	
Heart Catheterization	☐	☐		☐	☐	
Catheterization of Other Arteries	☐	☐		☐	☐	
Treadmill Stress Test	☐	☐		☐	☐	
Nuclear Stress Test	☐	☐		☐	☐	
Other Stress Test	☐	☐		☐	☐	
Heart Echocardiogram	☐	☐		☐	☐	
Neck Artery (Carotid) Ultrasound	☐	☐		☐	☐	
Coronary Calcium Score	☐	☐		☐	☐	
ABI (ankle-brachial indices) Exam	☐	☐		☐	☐	
Electrocardiogram (EKG)	☐	☐		☐	☐	
Holter Monitor or Event Monitor	☐	☐		☐	☐	

Please answer the questions below if you are experiencing any of the following problems:

Chest pain/tightness/pressure/discomfort ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it (sharp, dull, ache, etc.)_____

In what situations do you usually get the discomfort? ☐ Resting ☐ Anxiety/tension ☐ During Sleep ☐ During Activity

Please describe: _____

Does it radiate to other areas of your body? ☐ Yes ☐ No If yes, where? _____

How long does it usually last? _____ What helps it go away faster?_____

Shortness of breath ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it _____

In what situations do you usually get short of breath? _____ Resting _____ Anxiety/tension _____ During Sleep _____ During Activity

Please describe: _____

How long does it usually last? _____ What helps it go away faster?_____

Palpitations/fast heart rate ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it _____

In what situations do you usually have this feeling? _____ Resting _____ Anxiety/tension _____ During Sleep _____ During Activity

Please describe: _____

How long does it usually last? _____ What helps it go away faster?_____

Dizziness ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it _____

In what situations do you usually have this feeling? _____ Resting _____ Anxiety/tension _____ During Sleep _____ During Activity

Please describe: _____

How long does it usually last? _____ What helps it go away faster?_____

Pain in the calves of the legs or hips ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it _____

In what situations do you usually get the discomfort? _____ Resting _____ Anxiety/tension _____ During Sleep _____ During Activity

Please describe: _____

How long does it usually last? _____ What helps it go away faster?_____

Swelling of the feet/ankles ☐ Yes ☐ No (If Yes, please answer the following)

Approximately when did this begin? _____ How would you describe it _____

In what situations do you usually get the swelling? _____ Resting _____ Anxiety/tension _____ During Sleep _____ During Activity

Please describe: _____

How long does it usually last? _____ What helps it go away faster?_____

PAST MEDICAL HISTORY

List chronic medical conditions, serious illnesses, injuries or operations and the approximate year. Exclude normal pregnancies.

Illness, Injury, Operation	Year	Name of Hospital	City and State

Obstetrical: Number of pregnancies _____ Number of miscarriages ____ Number of abortions: ____ Number of living children _____

Have you ever had a transfusion? ___ Yes ___ No

Check if you have had any of the following:

☐	Pneumonia	☐	Stomach Ulcer	☐	Hepatitis	☐	Kidney Stone	☐	Rheumatic Fever	☐	Convulsion
☐	Asthma	☐	Hiatal Hernia	☐	Anemia	☐	Pelvic Infection	☐	Shingles	☐	Depression
☐	Emphysema	☐	Colon Polyps	☐	Phlebitis	☐	Venereal Disease	☐	Cancer	☐	Arthritis
☐	Gallstones	☐	Diverticulitis	☐	Thyroid Problem	☐	Tuberculosis	☐	Stroke	☐	Alcoholism

CURRENT MEDICATION AND SUPPLIMENT USAGE

List all medications, vitamins and supplements you take daily:

Name	Strength (mg, units, etc.)	Number of pills	Number of times taken daily (once, twice, etc.)

MEDICAL ALLERGIES AND PROBLEMS WITH MEDICATION

List all allergies (including foods, insects, etc.) and medications that you have not tolerated in the past

Name	Problem experienced

PERSONAL HABITS AND SOCIAL HISTORY

Please respond to the following:

Have you ever smoked? ☐ Yes ☐ No How many packs/day? ____ How many years?_____ Current smoker? ☐ Yes ☐ No

What year did you quit? _____ Any other tobacco use? ☐ Yes ☐ No Describe: _____

Estimate number of cups of coffee / number of caffeinated beverages consumed daily: _____

Do you drink alcohol? ☐ Yes ☐ No How many days per week? ____ Describe usage (beer, wine, etc.): _____

Do you sleep well? ☐ Yes ☐ No How many hours per night on average? _____

Do you wear seatbelts? ☐ Yes ☐ No How often? _____

Do you self Exam (breast or testicular)? ☐ Yes ☐ No

Check any of the following that you regularly use: ☐ Aspirin ☐ Pain Relievers ☐ Laxatives ☐ Cold / Allergy Medication ☐ Calcium ☐ Vitamins ☐ Other Suppliments

Do you have a history of substance use? ☐ Yes ☐ No Describe: _____

FAMILY MEDICAL CONDITIONS

Please indicate family members that have experienced any of the following medical problems (for extended family please indicate maternal [M] or paternal [P] for grandmother [GM], grandfather [GF], Aunt [A], or Uncle [U]):

	Mother	Father	Sibling (brother / sister)	Grandparent (maternal / paternal)	Aunt / Uncle (maternal / paternal)	Child (son / daughter)
High Blood Pressure						
Heart Attack						
High Cholesterol						
Diabetes						
Stroke						
Cancer (type)						
Tuberculosis						
Bleeding Disorder						
Alcoholism						
List other conditions below						

Mother living? ☐ Yes ☐ No If deceased, cause of death: _____

Father living? ☐ Yes ☐ No If deceased, cause of death: _____

Review of Systems continued

Please check indicating if you now experience or have had problems with any of the following:

	NO	NOW	PAST YEAR
GENERAL			
FEVER OR CHILLS	☐	☐	☐
APPETITE CHANGE	☐	☐	☐
WEIGHT GAIN	☐	☐	☐
WEIGHT LOSS	☐	☐	☐
NIGHT SWEATS	☐	☐	☐
EYES			
BLURRED VISION	☐	☐	☐
DOUBLE VISION	☐	☐	☐
CATARACTS	☐	☐	☐
GLAUCOMA	☐	☐	☐
ENT			
HEARING LOSS	☐	☐	☐
FREQUENT EAR PAIN	☐	☐	☐
RINGING IN EARS	☐	☐	☐
SINUS TROUBLE	☐	☐	☐
ALLERGIES OR HAYFEVER	☐	☐	☐
NOSE BLEEDS	☐	☐	☐
HOARSENESS	☐	☐	☐
MOUTH ULCERS	☐	☐	☐
CARDIOVASCULAR			
HIGH BLOOD PRESSURE	☐	☐	☐
CHEST PAIN OR TIGHTNESS	☐	☐	☐
IRREGULAR HEARTBEAT	☐	☐	☐
FAINTING OR DIZZINESS	☐	☐	☐
LEG CRAMPS WALKING	☐	☐	☐
SWOLLEN ANKLES OR FEET	☐	☐	☐
RESPIRATORY			
BRONCHITIS OR COUGH	☐	☐	☐
COUGHED BLOOD	☐	☐	☐
WHEEZING	☐	☐	☐
SHORTNESS OF BREATH	☐	☐	☐
GASTROINTESTINAL			
DIFFICULTY SWALLOWING	☐	☐	☐
HEARTBURN OR INDIGESTION	☐	☐	☐
ABDOMINAL PAIN	☐	☐	☐
NAUSEA OR VOMITING	☐	☐	☐
CONSTIPATION	☐	☐	☐
DIARRHEA	☐	☐	☐
RECTAL BLEEDING	☐	☐	☐
CHANGE IN BOWEL HABIT	☐	☐	☐
BLACK STOOLS	☐	☐	☐
VOMITED BLOOD	☐	☐	☐
YELLOW JAUNDICE	☐	☐	☐
ENDOCRINE			
FATIGUE	☐	☐	☐
SENSITIVE TO HEAT OR COLD	☐	☐	☐
THYROID GOITER OR SWELLING	☐	☐	☐
CHANGE IN THIRST	☐	☐	☐
HOT FLASHES	☐	☐	☐
IMPOTENCE	☐	☐	☐
DECREASED SEXUAL INTEREST	☐	☐	☐

	NO	NOW	PAST YEAR
GENITOURINARY			
PAINFUL URINATION	☐	☐	☐
FREQUENT URINATION	☐	☐	☐
SLOW STREAM	☐	☐	☐
URINATION AT NIGHT	☐	☐	☐
BLADDER CONTROL PROBLEM	☐	☐	☐
BLOOD IN URINE	☐	☐	☐
URINARY INFECTION	☐	☐	☐
KIDNEY STONES	☐	☐	☐
TESTICLE SWELLING OR PAIN	☐	☐	☐
PAINFUL MENSTRUAL PERIODS	☐	☐	☐
IRREGULAR VAGINAL BLEEDING	☐	☐	☐
PAINFUL INTERCOURSE	☐	☐	☐
VAGINAL DRYNESS	☐	☐	☐
MUSCULOSKELETAL			
JOINT PAIN	☐	☐	☐
BACK OR NECK PAIN	☐	☐	☐
ARM OR LEG PAIN	☐	☐	☐
MUSCLE PAIN OR CRAMPS	☐	☐	☐
SKIN / BREASTS			
DRY SKIN	☐	☐	☐
RASHES	☐	☐	☐
CHANGE IN MOLES OR GROWTHS	☐	☐	☐
PERSISTENT ITCHING	☐	☐	☐
SORE THAT DOES NOT HEAL	☐	☐	☐
HAIR LOSS	☐	☐	☐
BREAST LUMPS	☐	☐	☐
BREAST TENDERNESS OR PAIN	☐	☐	☐
NIPPLE DISCHARGE	☐	☐	☐
NEUROLOGICAL			
FREQUENT HEADACHES	☐	☐	☐
MIGRAINE HEADACHES	☐	☐	☐
NUMBNESS OF ARMS OR LEGS	☐	☐	☐
MUSCLE WEAKNESS	☐	☐	☐
POOR COORDINATION	☐	☐	☐
FALLS	☐	☐	☐
TREMOR OR SHAKING	☐	☐	☐
TROUBLE SLEEPING	☐	☐	☐
PSYCHIATRIC			
DEPRESSION	☐	☐	☐
ANXIETY	☐	☐	☐
MEMORY CHANGE	☐	☐	☐
COUNSELING OR TREATMENT	☐	☐	☐
HEMATOLOGIC / LYMPHATIC			
SWOLLEN GLANDS	☐	☐	☐
EASY BRUISING OR BLEEDING	☐	☐	☐
ALLERGIC / IMMUNOLOGIC			
RASHES	☐	☐	☐
DRUG REACTIONS	☐	☐	☐
OTHER (Write In Below)			
	☐	☐	☐
	☐	☐	☐

I certify that the information provided above is true to the best of my knowledge.

_____ _____

Patient Name **Legal Guardian Name (if patient under 18)**

_____ _____

Patient Signature **Legal Guardian Signature (if patient is under 18)**

_____

Date of Signature