Apheresis - LDL New Patient Health Questionnaire

Welcome to the Lipid Clinic! The following questionnaire will help us understand more about your health. Please answer the following questions by circling the appropriate response. We will review this with you at your visit. All of your records are kept in strict confidence and adhere to federal privacy guidelines (HIPAA).

Please provide us with the following information:

First Name: _____ Middle Name or Initial: _____

Last Name: _____

SSN: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Birthdate: _____ - _____ - _____ Age: _____ Sex: M/F (Circle One)

Family/Primary Care Physician: _____

PCP Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Who were you referred by? _____ Phone Number: _____

Referring Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Is there any additional information you would like us to be aware of?:

_____

_____

_____

Have you experienced, or are you presently experiencing:

	(Circle One)	
High Blood Pressure	Yes	No
Chest pain	Yes	No
Circulation problems If so, where?	Yes	No
Heart attack (Myocardial Infarction)	Yes	No
Peripheral Vascular Disease	Yes	No
Abdominal Aortic Aneurysm	Yes	No
Stroke or TIA (paralysis or mini strokes)	Yes	No
Fainting or "blackout" spells	Yes	No
Other cardiovascular disease(s)	Yes	No
Bypass surgery, angioplasty, stents or endarterectomy If so, when?	Yes	No
Ulcers or other stomach, intestine or rectal problems	Yes	No
Jaundice, hepatitis or cirrhosis	Yes	No
Gallstones or other gallbladder diseases	Yes	No
Pancreatitis	Yes	No
Kidney or bladder disease	Yes	No
Cancer If so, what type?	Yes	No
Numbness or tingling sensations If so, location on body:	Yes	No
Diabetes How high do your blood sugars normally run?	Yes	No
Muscle tremors, twitching or cramps	Yes	No
Gout or high uric acid	Yes	No
Thyroid or other hormone problems	Yes	No
Arthritis or other bone, muscle or joint disease	Yes	No
Blood disease(s) or bleeding problems	Yes	No
Surgery If so, what kind?	Yes	No
Hospitalizations within the last year If so, for what?	Yes	No
Do you presently smoke? If so, what is your average consumption?	Yes	No
Do you drink alcohol? Average number of drinks per week: _____	Yes	No

The following questions are for **females** only:

	(Circle One)	
Is it physically possible for you to become pregnant?	Yes	No
If yes, are you using birth control?	Yes	No
If no, have you experiences menopause?	Yes	No
If no, are you surgically sterile?	Yes	No
Hysterectomy?	Yes	No
Tubal ligation?	Yes	No
Hormone Replacement Therapy?	Yes	No
If yes, what type?		

The following questions are for **males** only:

	(Circle One)	
Are you currently being treated for erectile dysfunction disorder?	Yes	No
If yes, are you taking a prescription?	Yes	No
Brand name:		
Are you surgically sterile?	Yes	No

Family Health History:

Have any blood relatives (parents, siblings, children, aunts, uncles, etc.) experienced any of the following before the age of **60**?

	(Circle One)	
Heart Attack Who was it and how old were they?	Yes	No
Bypass surgery, angioplasty, stents, stroke and/or Abdominal Aortic Aneurysm (AAA) Who was it and how old were they?	Yes	No
High blood pressure Who?	Yes	No
High blood cholesterol or triglycerides Who?	Yes	No
Diabetes Who?	Yes	No
Circulation problems in legs, arms or neck - Peripheral Vascular Disease (PVD). Who? Describe where the circulation problem was:	Yes	No

Please list all medications you are currently taking:

	Medication	Dosage (mg, IU, etc.)	How often?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Are you allergic to any medications? Yes/No (Circle One)

If yes, please list them and what was the reaction:

Have you ever taken lipid lowering medication you had a reaction to? Yes/No (Circle One)

If yes, please list the medication and describe what kind of reaction:

Have you ever seen a dietician? Yes/No (Circle One)

If so, for what and when?

Last Visit	Date:
Personal Physician	/ /
Ophthalmologist (eye doctor)	/ /
Dentist	/ /