Women's Heart Program at Stony Brook Medicine

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Patient Questionnaire

The Women's Heart Program at Stony Brook Medicine is designed to help women of any age identify their risk of heart disease. Kindly complete the questionnaire below. Once we have reviewed your questionnaire, we will discuss it with you at your visit.

Name: _____

Telephone Number: _____

Email: _____

Date of Birth: _____

Questions:

Did your parent, brother, or sister ever have heart disease or coronary artery disease, a heart attack or coronary artery surgery or stents? (Before age 55 in men, before age 65 in women). CIRCLE ONE: YES -or- NO

If yes, please describe: _____

Is there a history of high cholesterol in your family (parents, mother, sister, brother)?

CIRCLE ONE: YES -or- NO

Has a doctor told you that you had a stroke or mini stroke?

CIRCLE ONE: YES -or- NO

Has a doctor told you that you had blockages in the blood vessels of your legs?

CIRCLE ONE: YES -or- NO

How many days per week do you exercise for at least 30 minutes of aerobic activity? (walking, biking, running) _____

How many days per week do you participate in resistance or weigh training? _____

Have you ever been told you have high blood pressure? CIRCLE ONE: YES -or- NO

Have you ever been told you have diabetes? CIRCLE ONE: YES -or- NO

Do you smoke cigarettes? CIRCLE ONE: YES -or- NO -or- QUIT

IF YES, for how long? _____

How often do you add salt to your food or eat salty foods (chips, pickles, soy sauce, pizza)?

_____

How many times/week do you eat out or order in?_____

How many alcoholic drinks do you usually have per week? _____

Are you regularly exposed to second-hand smoke at home? _____

Indicate your usual blood pressure: _____

Mark any that apply:

- O **Taking birth control pills**
- O **Reached or passed menopause (naturally or early through surgery or other treatment)**
- O **Taking estrogen, female hormones**
- O **None apply**

Have you ever had eclampsia or pre-eclampsia (severe high blood pressure in pregnancy)?

CIRCLE ONE: YES -or- NO

Have you ever had high blood pressure in pregnancy?

CIRCLE ONE: YES -or- NO

Have you ever had gestational diabetes (diabetes in pregnancy only)?

CIRCLE ONE: YES -or- NO

Have you ever received radiation treatment to your chest, neck or breast?

CIRCLE ONE: YES -or- NO

Have you ever received chemotherapy? CIRCLE ONE: YES -or- NO

If yes, what type? _____

Indicate the kinds of food you usually eat: _____

How well do you feel you are coping with stress? _____

During the past 2 months have you been feeling "blue" or down? _____