

Cardiovascular Assessment

These questions are designed to help determine your health status. Your answers are strictly confidential and will only be seen by your health assessor. However, should a significant health problem be detected, you will be given a letter to take to your GP.

Date:

Name:

Tel No:

Address:

E-mail:
(optional)

Age:

Date of Birth:

Height:

Weight:

Cardiovascular History:

Please put a for YES and for NO. Leave blank if unsure

Do you, or have you ever suffered from any of the following?

| | | | | | | | | | |
|--------------|--------------------------|-----------------|--------------------------|----------------------|--------------------------|-----------------|--------------------------|---------------------|--------------------------|
| Heart Attack | <input type="checkbox"/> | Angina | <input type="checkbox"/> | Recurrent Chest Pain | <input type="checkbox"/> | Palpitations | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | Irregular Pulse | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | Diabetes Type 1 | <input type="checkbox"/> | Diabetes Type 2 | <input type="checkbox"/> |

Do you currently take any medication? If yes, please state the name of the drug(s) you take, dosage and how often.

| Name of Drug | Dosage | Times a Day |
|--------------|--------|-------------|
| | | |
| | | |
| | | |
| | | |

Do you currently take any dietary supplements? If yes, please state the name of the supplements you take, dosage and how often.

| Name of Supplement | Dosage | Times a Day |
|--------------------|--------|-------------|
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| | | |

Exercise:

Do you do any form of exercise/activity?

If yes, what do you do?

How often do you do this?

Do you have a sedentary job/lifestyle?

Smoking Status:

Do you smoke? If yes, please tick cigarettes cigars pipe other

How many a day?

If you do not smoke, have you ever smoked? When did you stop?

Alcohol Status:

(one unit = 1/2 pt beer, small glass of wine, pub measure of spirits)

What is your average weekly consumption of alcohol in units?

If less than 1 unit, how many in a month?

Did you regularly drink more in the past? If so, how many units a week?

Family History:

Have close family members suffered from any of the following?

Please put **M** for Mother, **F** for Father, **S** for Sister or **B** for Brother

Stroke Heart Attack High Blood Pressure High Cholesterol

Diabetes Type 1 Diabetes Type 2

Assessment: (details to be entered by health assessor)

BMI: **B/P:** **2nd reading:** **Pulse:**
Waist: **Hips:** **W/H Ratio:** **PulmoLife:**
Heart Rate: **PPT:** **RI :** **SI:** **Vascular Age:**

Recommendations: