Heart Disease Risk Assessment Form

Patient Information

Name:

Date of Birth: Age:

Gender:

☐ Male

☐ Female

Contact Number:

Address:

Medical History

Previous heart disease diagnosis:

☐ Yes

☐ No

If yes, please specify: _____

Family history of heart disease:

☐ Yes

☐ No

If yes, please specify: _____

Existing medical conditions (e.g., diabetes, hypertension):

Lifestyle Factors

- Smoking status:
  - ☐ Never smoked
  - ☐ Former smoker
  - ☐ Current smoker

    If former or current smoker, indicate pack-years: _____
- Physical activity level (hours per week):
- Dietary habits:
- Alcohol consumption (units per week):

Physical Examination:

- Blood Pressure (mm Hg):
  - Systolic:
  - Diastolic:
- Height (cm):
- Weight (kg):
- Waist Circumference (cm):
- BMI (Body Mass Index):

Blood Test Results

- Total Cholesterol (mg/dL):
- LDL Cholesterol (mg/dL):
- HDL Cholesterol (mg/dL):
- Triglycerides (mg/dL):
- Fasting Blood Glucose (mg/dL):

Assessment of Risk Factors

- Age:
- Gender:
  - ☐ Male
  - ☐ Female
- Ethnicity:

Heart Disease Risk Score

- 10-Year Risk Score:
- Risk Category:
  - ☐ Low
  - ☐ Moderate
  - ☐ High

Interpretation and Recommendations

- Interpret the risk score and provide explanations.
- Recommend lifestyle modifications, medications, or further tests as needed.

Follow-Up

Healthcare Provider's Signature:

Date: