2841 DeBarr Rd. Suite 43
Anchorage, AK 99508
Phone 907-274-7847
Fax 907-274 7845

HIGH CHOLESTEROL HISTORY

Please bring old records including any laboratory and procedures to first visit

Date: ________________________ Date of Diagnosis: ________________

Name: ____

Address: ____

City: ___________________________State: __________ Zip: ___________

Birth Date: ______________________ Age: ___________ Gender: _______

Home phone: ____________________ Work Phone: __________________

E Mail: ____

Source of referral: Self referred Physician/Provider Other

Referring/Primary Care Provider and telephone number:

____

Family Heritage (Circle all that apply):

White American Indian/Alaska Native Black/African American

Asian Native Hawaiian/Pacific Islander Spanish/Latino/Hispanic

Occupation: ______________________Hours worked per week: __________

Do you have any of the following health concerns?

Heart disease
High blood pressure
Eye or vision problems

Numbness/pain in extremity
Difficulty with sexual function
Stroke

Family History:

Diabetes *If yes, whom:* ________________________________
Thyroid disease *if yes, whom:* ________________________________
Heart disease *if yes, whom:* ________________________________
High blood pressure *if yes, whom:* ________________________________
High cholesterol *if yes, whom:* ________________________________
Cancer *If yes whom and what type:* ____________________

____
Other family illnesses ____
____
____

Diet: Briefly describe your diet

____
____
____
____

Exercise: What type of exercise do you perform and how often?

What type of medical problems or surgeries have you had in the past?

Diagnosis/Date

Medications

Allergies List medication and what type of reaction

Cholesterol Treatment

When where you first diagnosed with high cholesterol?

When was the first test for cholesterol performed?

Is there a family history of high cholesterol? If yes, whom?

Have any family members experienced heart attacks, strokes, non traumatic amputations younger than 60 years or age?

What cholesterol medications have been tried in the past? Why were they discontinued or changed?

What types of vascular problems have you experienced in the past and what type of treatment was rendered?

Do you experience pain in your legs which is relieved by rest? How long do your symptoms last and when do you begin having these symptoms?

Do you have a history of “mini stokes” or strokes?

Have you ever had an exercise stress test? Who performed it, where, and when?

____

Have you ever undergone a heart catheterization (dye injected into heart arteries)? Who performed it, where, and when?
____

____

Have you ever had an ultrasound (Doppler) of your carotid arteries?

____

What are your health care goals and how can we facilitate those goals?
____
____
____

Patient signature: ________________________________Date:_________

Reviewed by: ___________________________________Date:__________