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? ____________________