HEALTH SCIENCE RESEARCH 7505 FANNIN ST, Ste 210, Houston, TX 77054 713-790-9191 ©

Cholesterol Screening Questionnaire

Name ____ Date _____________

If you do not remember a value, or are unsure, just put down what you think it may have been

		CIRCLE
1.	**Do you have elevated cholesterol levels?** **What is your total cholesterol value? ___________.**	**Yes / No**
2.	**How many times was your cholesterol tested before being put on medications? __________**	
3.	**What cholesterol medications are you taking?** • _______________________________ how long __________ • _______________________________ how long __________ • _______________________________ how long __________	
4.	**What natural supplements have you used, if any, or are taking now for cholesterol?** • _______________________________ how long __________ • _______________________________ how long __________ • _______________________________ how long __________ • _______________________________ how long __________	
5.	**Do you have a family history of heart disease, diabetes, or cholesterol over 300?**	**Yes / No**
6.	**What is your LDL value? ______________ Date last done ______________**	
7.	**What is your HDL value? ______________ Date last done ______________**	
8.	**What do your TRIGLYCERIDES average? _______________ Date last done ___________**	
9.	**Was your blood homocysteine checked the last time your cholesterol was?** **If so, what was it? __________ Date last done ____________**	
10.	**Have you had your blood C-reactive protein checked? Approximate date: ____________** **What was the value (or was it high)? _______________.**	**Yes / No**
11.	**Have you had any advanced lipid testing done, such as the VAP (Vertical Automated Profile), NMR (Nuclear Magnetic Resonance), or Lipoprotein Particle Profile LPP (SpectraCell)?**	**Yes / No**
12.	**Have you had a lipoprotein "little a" [Lp(a)] level done?** **Was it high or normal/low? High________**	**Yes / No**
13.	**Were you ever told you have high blood pressure?** **If so, what does your blood pressure average? _______/______.**	**Yes / No**
14.	**Do you smoke?** **If so, how many years? ___________. How many packs/day?__________ Packs X Yrs ______**	**Yes / No**
15.	**Do you consume more than 4 alcoholic drinks per week?**	**Yes / No**
16.	**Are you hypothyroid (low thyroid hormone activity) or feel that you are?**	**Yes / No**
17.	**If you know, what does your blood sugar average? _____________.**	
18.	**Are you peri-menopausal (near menopause) or do you know if any of your hormones are low?**	**Yes / No**
19.	**Do you have any inflammatory condition from disease (eg, arthritis, intestinal, diabetes, metabolic syndrome, fatty liver, polycystic ovaries, other) or injury?**	**Yes / No**
20.	**Do you have any history of liver problems or elevated liver enzymes?**	**Yes / No**
21.	**Is stress a problem with you now (physical, emotional, general)?**	**Yes / No**
22.	**Are you or have you been on a low fat diet? Did it lower cholesterol?**	**Yes / No**
23.	**Do you suffer from depression or anxiety? (whether or not your take medication)**	**Yes / No**
24.	**Do you frequently eat a lot of carbohydrates, such as bread, rice, pasta, cookies, pastries, confections, sweets, soda, juices, etc.?**	**Yes / No**
25.	**Are you very athletic?** **Do you do mainly endurance sports? Yes / No If yes, hours each week:**	**Yes / No**
26.	**Do you have angina (chest pain from the heart), cardiac insufficiency, or congestive heart**	**Yes / No**

	failure?	
27.	Have you ever had “TIAs” or a stroke? If so, when? ________________	Yes / No
28.	Have you ever been told of poor circulation, or had tests indicating peripheral arterial disease?	Yes / No
29.	Do you follow a special diet for your cholesterol, triglycerides, or other condition? What is the name of the diet? ________________________________	Yes / No
30.	Have you had a “heart attack?” Il so, when and where, and did you receive a stent/pacemaker/ ICD device? Please give details below, and name of hospital and cardiologist.	Yes/ No

31. Please add any history regarding your heart or blood vessels that might be important, such as symptoms, complaints, hospitalizations, surgeries:

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