1. What is your age?  

2. What is your ethnicity? (choose all that apply)  
- Caucasian  
- African-American  
- Hispanic  
- Southeast Asian  
- Other Asian  
- Other  

3. Do you smoke?  
- Yes  
- No, Never  
- No, Quit  

4. Is your blood pressure over 140/90?  
- Yes  
- No  
- Don't Know  

5. What is your blood pressure?  
- Self Reported by Patient  

6. Has your cholesterol ever been checked?  
- Yes  
- No  
- Don't Know  

7. What is your total cholesterol?  
- Self Reported by Patient  

8. Is your HDL (good cholesterol) less than 40 mg/dL?  
- Yes  
- No  
- Don't Know  

9. What is your good cholesterol (or HDL)?  
- Self Reported by Patient  
- Don't Know  

10. Are you currently taking medicines for high cholesterol?  
- Yes  
- No  
- Don't Know  

11. Which of these medicines are you currently taking for high cholesterol?  
- Statin  
- Fibrate  
- Niacin  
- I don't know  
- Other  

12. Has your father/brother had a heart attack, stroke, or other heart problem before age 55?  
- Yes  
- No  
- Don't Know  

13. Has your mother/sister had a heart attack, stroke, or other heart problem before age 65?  
- Yes  
- No  
- Don't Know  

14. Do you have diabetes/prediabetes OR a fasting blood sugar of 110 mg/dL or higher?  
- Yes  
- No  
- Don't Know  

15. Are you currently taking medicine to control blood sugar?  
- Yes  
- No  
- Don't Know  

16. Is your BMI greater than 25?  
- Yes  
- No  
- Don't Know  

17. Do you get less than 30 minutes of exercise on most days?  
- Yes  
- No  

18. Have you had a heart attack or have you been told that you have angina?  
- Yes  
- No  
- Don't Know  

19. Do you experience any of the following that limit your activities?  
- Chest, jaw, shoulder or neck discomfort w/ activity  
- Palpitations  
- Chest, jaw, shoulder or neck discomfort at rest  
- Fatigue  
- Shortness of breath  
- Leg Pain w/ walking  
- Fainting without explanation  
- Stroke or mini-stroke  

20. Are you currently pregnant?  
- Yes  
- No  
- Don't Know  

21. Did you have high blood sugar during your pregnancy (gestational diabetes)?  
- Yes  
- No  
- Don't Know  
- Not Applicable  

22. Did you have high blood pressure during your pregnancy?  
- Yes  
- No  
- Don't Know  
- Not Applicable  

23. Did you have preeclampsia or toxemia during your pregnancy?  
- Yes  
- No  
- Don't Know  

24. Have you reached menopause?  
- Yes  
- No  
- Don't Know  

25. Was your uterus removed?  
- Yes  
- No  
- Don't Know  

26. Were your ovaries removed?  
- Yes  
- No  
- Don't Know  

27. Are you on hormone replacement treatment?  
- Yes  
- No  
- Don't Know  

28. Do you have polycystic ovary syndrome (PCOS)?  
- Yes  
- No  
- Don't know  

29. Is this your primary care physician/provider?  
- Yes  
- No  

30. Do you have a primary care provider other than your GYN provider?  
- Yes  
- No  

For Completion by Healthcare Professional Only  
* Enter the patient's BP, Cholesterol and HDL if incomplete.  

Was referral recommended?  
- Yes  
- No  

If yes, referred to whom?  
- PCP  
- Cardiologist  
- Endocrinologist  
- NP  
- PA  
- Other  

Referral Date:  

Survey #: 51215