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):

Medication List: (Please list out all medications you are currently taking, including name, dosage, and frequency)

Other pertinent complaint:

Physical Examination:

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