Heart Disease Screening Tool

Survey Date: ☐☐ / ☐☐ / ☐☐☐☐

The Society for Cardiovascular Angiography and Interventions — SCAI

Abbott Vascular

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 ○ Not Applicable

24. Have you reached menopause?

○ Yes ○ No ○ Don't Know If yes, at what age? ☐☐

25. Was your uterus removed?

○ Yes ○ No ○ Don't Know If yes, at what age? ☐☐

26. Were your ovaries removed?

○ Yes ○ No ○ Don't Know If yes, at what age? ☐☐

27. Are you on hormone replacement treatment?

○ Yes ○ No ○ Don't Know If yes, for how long in years? ☐☐

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: ☐☐ / ☐☐ / ☐☐☐☐

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