Cardiovascular/Cerebrovascular Risk Profile

Purpose: Record history of cardiovascular/cerebrovascular disease.

When: This form should be completed just once at:
1) The baseline visit for newly enrolled patients; or
2) The upcoming followup visit for patients already enrolled; or
3) In a timely manner for patients who are deceased or who missed the last 3 consecutive in-person visits. (Note: The visit ID code should be ''N'' in this case).

By whom: Clinic coordinator (by interview with patient and/or review of medical records).

A. Clinic, patient, and visit identification

1. Clinic ID code: ____ ____ ____ ____

2. Patient ID#: ____ ____ ____ ____

3. Patient name code: ____ ____ ____ ____ ____

4. Date of visit: ____ ____–____ ____ ____–____ ____
day mon year

5. Visit ID code: ____ ____ ____

B. Cardiovascular/cerebrovascular risks

6. Cigarette smoking

a. Has the patient ever smoked more than 100 cigarettes:

Yes (1)
No (2) → 7.
Don't know (3) → 7.

b. At what age did the patient start smoking cigarettes: ____ ____ years

c. On average, when the patient was smoking, what was the number of cigarettes he/she smoked per day: ____ ____ ____ cigarette(s)/day

d. At what age did the patient stop smoking *(enter ''N'' if he/she is still smoking):* ____ ____ years

7. Has the patient ever been diagnosed with any of the following conditions

a. Coronary heart disease:
Yes (1)
No (2)
Don't know (3)

b. Peripheral vascular disease:
Yes (1)
No (2)
Don't know (3)

c. Stroke:
Yes (1)
No (2)
Don't know (3)

d. Has the patient's father or any of patient's brothers had a heart attack by the time they were 55 years old:
Yes (1)
No (2)
Don't know (3)

e. Has the patient's mother or any of patient's sisters had a heart attack by the time they were 65 years old:
Yes (1)
No (2)
Don't know (3)

C. Source of information

8. How was the information obtained *(check all that apply)*

a. Interview with patient (1)
b. Review of medical records (1)
c. Other *(specify)* (1)

_____
specify

D. Administrative information

9. Date form reviewed:

____ ____–____ ____ ____–____ ____
day mon year

10. Clinic coordinator ID: ____ ____

11. Clinic coordinator signature:

_____