CARDIOVASCULAR

RISK ASSESSMENT

PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

Gender : Male Female

CARDIOVASCULAR HEALTH

Any history of heart disease or stroke? Yes No

Family history of heart disease or stroke? Yes No

Blood pressure levels:

Cholesterol levels:

Diabetes diagnosis: Yes No

BMI (weight/height ratio):

Any substance use: Yes No

If yes, please specify:

Any history of mood disorder: Yes No

If yes, please specify:

THANK YOU FOR YOUR INFORMATION