HYPERLIPIDEMIA

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number : **Gender** : ☐ Male ☐ Female

MEDICAL HISTORY

Do you have a diagnosis of high cholesterol, hypercholesterolemia, or hyperlipidemia?

☐ Yes **If yes, how long have you been diagnosed?**

☐ No

Have you been diagnosed with diabetes? ☐ Yes ☐ No

Do you have a history of heart disease? ☐ Yes ☐ No

Do you have any immediate family member with high cholesterol? ☐ Yes ☐ No

LIFESTYLE AND DIETARY HABITS

How would you describe your typical diet?

☐ Balanced and healthy

☐ High in sodium/salt

☐ High in processed foods

☐ Other (please specify): _____

How often do you consume foods high in cholesterol (e.g., red meat, full-fat dairy)?

☐ Rarely or never ☐ Occasionally ☐ Frequently

Do you engage in regular physical activity?

☐ Sedentary ☐ Low activity ☐ Moderate activity ☐ Active

Do you smoke or use tobacco products? ☐ Yes ☐ No ☐ Former smoker

THANK YOU FOR YOUR INFORMATION

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SYMPTOMS

Please indicate the frequency of the following symptoms over the past few months:

Leg Cramps, mostly in your calves:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly
Pain in your feet or toes:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly
Chest pain or discomfort:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly
Trouble breathing or shortness of breath when you're active:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly
Confusion or trouble speaking:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly
Weakness, often in your arm:	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently	☐ Constantly

BLOOD CHOLESTEROL MONITORING

Have you had your cholesterol levels checked recently?

- ☐ **Yes, and they were within the normal range**
- ☐ **Yes, and they were high**
- ☐ **No, I haven't checked recently**

If you answered 'Yes' to any of the symptoms or have other risk factors, contact us now.

THANK YOU FOR YOUR INFORMATION