HYPERLIPIDEMIA

CHRONIC DISEASE MANAGEMENT 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

Do you know your last cholesterol numbers? Yes No

If yes, please list the following:.

LDL: HDL: Total Cholesterol: Triglyceride:

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

Do you have any immediate family member with cardiovascular disease? Yes No

DIET AND MEDICATION HISTORY

Have you been on any special diet to help lower your cholesterol? Yes No

Have you ever been prescribed medications for high cholesterol? Yes No

If yes, please list the medications.

THANK YOU FOR YOUR INFORMATION