THE POLYCLINIC
Part of Optum®

Lipid Clinic New Patient Form

Name _____ DOB ____/_____/_____ Ethnicity_____

Primary Care Provider _____ Cardiologist _____ Endocrinologist _____

Marital Status *(Please circle)*
Single Married Partner Divorced Widowed

Occupation _____

Please list any specific concerns, questions, or goals that you would like to discuss at your visit:
(Examples: having a heart attack, stroke, liver problems, etc) _____
_____

Cardiovascular Health & History:

Family History:
Please obtain as much information as possible, focusing on high cholesterol, high blood pressure, diabetes, and heart problems with their ages of occurrence:

Mother _____
Father _____
Sibling (older/younger) _____
Sibling (older/younger) _____
Sibling (older/younger) _____
Maternal Grandmother _____
Maternal Grandfather _____
Paternal Grandmother _____
Paternal Grandfather _____

Personal History:
Have you had problems with cholesterol lowering medications in the past? ☐ Yes ☐ No
If yes, please list medication(s) and reaction(s):
_____
_____

Have you taken any cholesterol lowering supplements?
☐ Yes ☐ No *If yes, please list supplement(s) and reaction(s):*_____
_____

What, if any, concerns do you have about cholesterol lowering medications? _____
_____

Past Medical History:

Please check all that apply & your age when diagnosed/occurred:

☐ Pancreatitis _____
☐ High Cholesterol _____
☐ High Blood Pressure _____
☐ Heart Attack _____
☐ Heart Problems _____
☐ Stroke _____
☐ Diabetes _____
☐ Aortic Aneurysm _____
☐ Kidney Problems _____
☐ Liver Problems _____
☐ Poor blood flow to extremities _____
☐ Thyroid Problems _____
☐ Rheumatoid Arthritis _____
☐ Lupus _____
☐ Psoriasis _____
☐ Migraines with Aura _____
☐ Polycystic Ovarian Syndrome _____
☐ Schizophrenia _____
☐ Gout _____
☐ Osteoporosis _____
☐ Obstructive Sleep Apnea _____
☐ Snoring, headache, and daytime tiredness _____
☐ Numbness, tingling, burning in hands and/or feet _____
☐ Fatty Liver _____
☐ Gestational Diabetes _____
☐ Pre-eclampsia _____
☐ Pre-term labor (<37 weeks) _____
☐ H. Pylori Infection _____
☐ Erectile Dysfunction _____
☐ Periodontal Disease _____
☐ Breast Cancer survivor _____
If yes, ☐ radiation ☐ chemo

Do you take any supplements? ☐ Yes ☐ No If yes, please list: _____
_____

Lifestyle Questions:

Smoking History:

Please circle: cigarettes pipe cigars
chewing tobacco marijuana e-cigarettes

☐ Never used
☐ Prior usage: _____ x ___ years. Quit year _____
☐ Current usage: _____ x ___ years
☐ Occasional usage: _____

If you are an active user and previously quit, what helped in the past? _____
_____

Alcohol Intake:

☐ Never
☐ Occasional: _____ / year
☐ Monthly: _____ / month
☐ Weekly: _____ / week
☐ Daily: _____ / day

Types of Alcohol:
☐ Beer
☐ Wine
☐ Liquor
☐ Mixed drinks
☐ Other: _____

Oral Care:

How many times a day do you brush your teeth? ___/day
How often do you floss? _____
Do your gums bleed? ☐ Yes ☐ No
When was your last dental cleaning? _____

"Typical Day" Dietary Intake:

Please list examples & types of foods:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Desserts _____

Are there any foods you can't or don't eat for any reason? _____
_____

How many times a week do you eat fast food, order take out, or eat out at a restaurant? _____

How many servings (fists) of **vegetables** (excluding lettuce, carrots, beets, peas, potatoes, & corn) do you eat **each day**? _____

How many egg yolks **a week** do you eat?
☐ ≥7 ☐ 6-7 ☐ 3-5 ☐ 2 or less

How much **water** do you drink **each day**? _____

How often do you drink sodas (diet or regular), energy/sports drinks, juice, or sweet tea? _____

"Typical Week Physical Activity:

Please include length of time & how often:
Walking _____
Running _____
Cycling _____
Swimming _____
Gardening/Yardwork_____
Weights/Strength training _____
Other _____

Do you have physical limitations? ☐ Yes ☐ No
_____

Sleep:

How many hours a night do you sleep? _____
Do you snore? ☐ Yes ☐ No
Do you feel well rested? ☐ Yes ☐ No
Do you wake up with a headache in the morning?
☐ Yes ☐ No

Stress:

How would you rate your stress level?
At work: ☐ N/A ☐ minimal ☐ moderate ☐ high
At home: ☐ N/A ☐ minimal ☐ moderate ☐ high
Does it feel manageable? ☐ Yes ☐ No

Other:

What are your hobbies and/or how do you like to relax? _____

Is there anything about yourself you'd like us to know? _____
_____

Patient Health Questionnaire (PHQ-9)

This questionnaire is an important part of providing you with the best healthcare possible.

Name: _____ **Today's Date:** _____

MRN # (to be filled in by staff): _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed or hopeless.	0	1	2	3
If you answered a "2" or "3" to either of the above questions, please answer the remaining 7 questions.				
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
Staff: Please subtotal each column. **Then add columns 1, 2, & 3 for *Total Score* =** _____				