Cholesterol Questionnaire

When your client has a history of high cholesterol, ask your client for this information. Record as much information as your client can give you.

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. Most recent cholesterol reading?_____

2. Most recent HDL or most recent Cholesterol/HDL ratio? _____

3. Name of medication? _____

4. Date medication was started? _____

5. Is personal physician satisfied with results of recent cholesterol levels? ___Yes ___No
(If no, please provide information): _____

6. Name and address of physician, or health facility, that will have the most complete records?
_____
_____

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