Heart Disease Risk Evaluation Form

Dear [Patient's Name],

We appreciate your commitment to monitoring your heart health. Please take a moment to fill out the following risk evaluation form:

Personal Information

Name: ___________________________

Date of Birth: ___________________________

Contact Number: ___________________________

Health History

1. Do you have a family history of heart disease? (Yes/No)

2. Are you currently experiencing any of the following symptoms? (Check all that apply)

- [ ] Chest pain
- [ ] Shortness of breath
- [ ] Palpitations
- [ ] Dizziness

Lifestyle Factors

3. How often do you exercise? (None / Occasionally / Regularly)

4. Do you smoke? (Yes/No)

5. How would you rate your diet? (Poor / Fair / Good / Excellent)

Additional Information

6. Please list any medications you are currently taking:

____

Signature

_________________________ (Patient's Signature)

Date: ________________

Thank you for your participation.

Sincerely,

[Your Clinic/Organization Name]