

HEALTH HISTORY UPDATE

PATIENT'S NAME _____
Last
First
Date of Birth

Have there been any changes in your health since your last dental visit? **Yes/No**

<p>Patient: Include medications, medication changes, major illnesses, hospitalizations, operations, pregnancy, diet changes, allergies, high blood pressure, diabetes, or heart problems.</p>	<p>Tobacco Use: Current Former Never Form: Frequency: Referral:</p> <p>Diet Screening: Low Risk Moderate Risk High Risk Referral:</p> <p>Blood Pressure: Referral:</p> <p>Staff: Ask about tobacco use and document, advise those who use to quit, and refer to quitline. Screen patient for dietary and nutritional risk. Measure and record blood pressure.</p>
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RISK ASSESSMENT FOR CARDIOVASCULAR DISEASE (CVD)

This risk assessment is designed to identify patients who are at high risk of developing cardiovascular disease. If two or more risk factors are identified, refer the patient to an appropriate medical provider for further evaluation. Use only as a screening tool, and not to make a diagnosis of cardiovascular disease.

1. **Age?** _____ (Higher risk: Women: ≥ 55 years old, Men: ≥ 45 years old)
2. **Do you smoke or live or work with others who smoke tobacco daily?** _____ (Answer yes if you have smoked any tobacco in the past month or have been exposed to secondhand smoke.)
3. **Have you been told your blood pressure is too high ($\geq 140/90$ mm Hg)?** _____ (Normal: <120 and <80 mm Hg
Prehypertension 120-139 or 80-89 mm Hg; Stage 1 HTN 140-159 or 90-99 mm Hg; Stage 2 HTN ≥ 160 or ≥ 100 mm Hg)
4. **Is your total cholesterol level ≥ 240 mg/dL?** _____ (TC < 200 mg/dL, LDL < 100 mg/dL, HDL ≥ 60 mg/dL, TG < 150 mg/dL)
5. **Is your diet high in saturated fat, trans fat and/or dietary cholesterol?** _____ (Limit saturated fat and avoid trans fat)
6. **Is your fasting blood sugar level ≥ 126 mg/dL?** _____ (Desirable: < 100 mg/dL; Prediabetes: 100-125 mg/dL)
7. **Do you have diabetes or have a family history of diabetes?** _____ (Parent, brother or sister who has diabetes)
8. **Are you or have you ever been under the care for heart problems?** _____ (Type: _____)
9. **Do you have a family history of heart disease?** _____ (Father/brother had heart attack before age 55; mother or sister had a heart attack before age 65; mother, father sister, brother or grandparents had a stroke)
10. **Are you fairly inactive? Do you exercise fewer than 3 times a week?** _____ (Min: 30 mins. 5 days per week)
11. **Are you overweight according to the BMI?** _____ (Normal weight: < 24.9 , Overweight: 25-29.9, Obese: 30 or greater)

_____ _____
Date **Patient signature**

