The Christ Hospital Health Network
Women's Heart Center

WOMEN'S HEART CENTER
INITIAL VISIT QUESTIONNAIRE
New Patient History

Name: _____ Today's Date: _____

Date of Birth: _____ MRN: _____

A message from Dr. Quesada and the Women's Heart Center Team:

Thank you for selecting The Women's Heart Center to provide your cardiovascular care. The Women's Heart Center is dedicated to using best practice and improving the overall health and wellbeing of our patients. We ask all new patients to complete this intake packet to better understand your medical history, current state of health, and wellbeing. The information you provide also helps us better understand how social determinants of health affect heart health and outcomes. Social determinants of health are the conditions in the environment where people are born, live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Please read the questions carefully and answer to the best of your ability. Ask the care team if you need help. The information you provide will be treated as part of your medical record and will be kept confidential per HIPAA guidelines. When answering a multiple-choice question, unless otherwise directed, please only select <u>one</u> answer.

Odayme Quesada, MD, MHS, FACC
Medical Director, The Christ Hospital Women's Heart Center

ANGINA CLASS QUESTIONS

1. Which symptom, if any, do you predominantly feel? ☐ Chest Pain ☐ Shortness of Breath ☐ Fatigue
2. Are you able to exercise vigorously without chest pain, shortness of breath, or fatigue? ☐ Yes ☐ No
3. Can you walk up more than one flight of stairs or walk 1-2 blocks at a normal pace without chest pain, shortness of breath, or fatigue? ☐ Yes ☐ No
4. Can you perform all your usual activities at a normal pace, one flight of stairs, or walk one block without experiencing chest pain, shortness of breath, or fatigue? ☐ Yes ☐ No
5. Do you have chest pain, shortness of breath, or fatigue at rest or with minimal activity? ☐ Yes ☐ No
6. Are you having random or sporadic chest pain at rest? ☐ Yes ☐ No
   a. If yes, how many episodes of chest pain are you experiencing on average? # _____, per (check one)……. ☐ Day ☐ Week ☐ Month
   b. If yes, how severe is your chest pain on a scale of 1-10, with 10 being the worst? # _____

SEATTLE ANGINA CLASS QUESTIONNAIRE

1. The following is a list of activities that people often do during the week. Although for some people with several medical problems it is difficult to determine what it is that limits them, please go over the activities listed below and indicate how much limitation you have had **due to chest pain, chest tightness, or angina over the past 4 weeks.**

Place an x in one box on each line

Activity	Extremely Limited	Quite a bit Limited	Moderately Limited	Slightly Limited	Not at all Limited	Limited for other reasons or did not do the activity
Dressing yourself	☐	☐	☐	☐	☐	☐
Walking indoors on level ground	☐	☐	☐	☐	☐	☐
Showering	☐	☐	☐	☐	☐	☐
Climbing a hill or a flight of stairs without stopping	☐	☐	☐	☐	☐	☐
Gardening, vacuuming, or carrying groceries	☐	☐	☐	☐	☐	☐
Walking more than a block at a brisk pace	☐	☐	☐	☐	☐	☐
Running or jogging	☐	☐	☐	☐	☐	☐
Lifting or moving heavy objects (e.g. furniture, children)	☐	☐	☐	☐	☐	☐
Participating in strenuous sports (e.g. swimming, tennis)	☐	☐	☐	☐	☐	☐

2. Compared with 4 weeks ago, how often do you have **chest pain**, **chest tightness**, **or angina** when doing your most strenuous activities?

I have had **chest pain**, **chest tightness**, **or angina**...

Much more often	Slightly more often	About the same	Slightly less often	Much less often	I have had **no chest pain** over the last four weeks
☐	☐	☐	☐	☐	☐

3. Over the past 4 weeks, on average, how many times have you had **chest pain**, **chest tightness**, **or angina**? I have had **chest pain**, **chest tightness**, **or angina**...

4 or more times per day	1-3 times per day	3 or more times per week but not every day	1-2 times per week	Less than once a week	None over the past 4 weeks
☐	☐	☐	☐	☐	☐

4. Over the past 4 weeks, on average, how many times have you had to take nitroglycerin (nitroglycerin tablets or spray) for your **chest pain**, **chest tightness**, **or angina**?

I have taken nitroglycerin...

4 or more times per day	1-3 times per day	3 or more times per week but not every day	1-2 times per week	Less than once a week	None over the past 4 weeks
☐	☐	☐	☐	☐	☐

5. How bothersome is it for you to take your pills for **chest pain**, **chest tightness or angina** as prescribed?

Extremely bothersome	Quite a bit bothersome	Moderately bothersome	Slightly bothersome	Not bothersome at all	My doctor has not prescribed pills
☐	☐	☐	☐	☐	☐

6. How satisfied are you that everything possible is being done to treat your **chest pain**, **chest tightness**, **or angina**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
☐	☐	☐	☐	☐

7. How satisfied are you with the explanations your doctor has given you about your **chest pain**, **chest tightness**, **or angina**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
☐	☐	☐	☐	☐

8.Overall, how satisfied are you with the current treatment of your **chest pain**, **chest tightness**, **or angina**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
☐	☐	☐	☐	☐

9.Over the past 4 weeks, how much has your **chest pain**, **chest tightness**, **or angina** limited your enjoyment of life?

It has extremely limited my enjoyment of life	It has limited my enjoyment of life quite a bit	It has moderately limited my enjoyment of life	It has slightly limited my enjoyment of life	It has not limited my enjoyment of life at all
☐	☐	☐	☐	☐

10. If you had to spend the rest of your life with your **chest pain, chest tightness, or angina** the way it is right now, how would you feel about this?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
☐	☐	☐	☐	☐

11. How often do you think or worry that you may have a heart attack or die suddenly?

I can’t stop thinking or worrying about it	I often think or worry about it	I occasionally think or worry about it	I rarely think or worry about it	I never think or worry about it
☐	☐	☐	☐	☐

THE UNIVERSITY OF CALIFORNIA SAN DIEGO SHORTNESS OF BREATH

Please rate the shortness of breath you experience when you do, or if you were to do, each of the following tasks. **Do not skip any items**. If you've never done a task or no longer do it, give your best guess of the shortness of breath you would have while doing that activity.

When I do, or if I were to do, the following tasks, I would rate my shortness of breath as:
0 – None at all
1
2
3
4 – Severe
5 – Maximum or unable to do because of shortness of breath

1. At rest	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
2. Walking on a level at your own pace	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
3. Walking on a level with others your age	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
4. Walking up a hill	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
5. Walking up stairs	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
6. While eating	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
7. Standing up from a chair	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
8. Brushing teeth	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
9. Shaving and/or brushing hair	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
10. Showering/bathing	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
11. Dressing	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
12. Picking up and straightening	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
13. Doing dishes	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
14. Sweeping/vacuuming	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
15. Making bed	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
16. Shopping	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
17. Doing laundry	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
18. Washing car	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
19. Mowing lawn	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
20. Watering lawn	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
21. Sexual activities	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

How much do these limit you in your daily life?

22. Shortness of breath ……	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
23. Fear of "hurting myself" by overexerting …….	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○
24. Fear of shortness of breath ……	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○

USCD PULMONARY REHABILITATION SHORTNESS-OF-BREATH QUESTIONNAIRE

EQ – 5D – 5L Paper Self-Complete

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN / DISCOMFORT

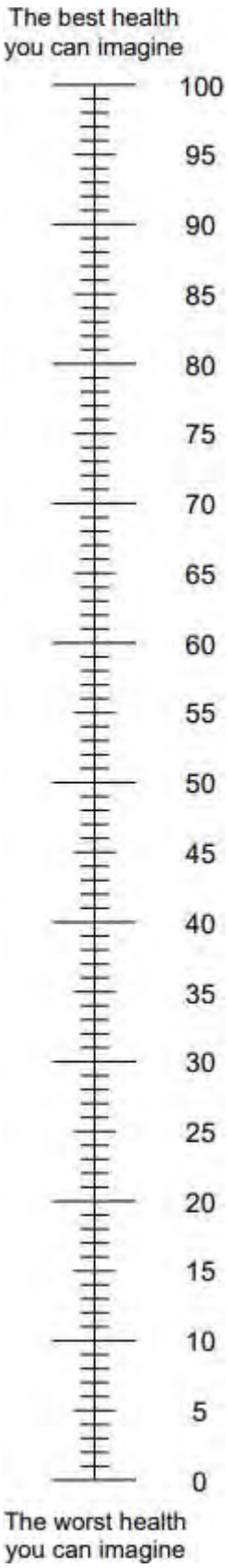
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I am extreme pain or discomfort ☐

ANXIETY / DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



QUALITY OF LIFE

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf: ○ Yes, limited a lot ○ Yes, limited a little ○ No, not limited at all

3. Climbing several flights of stairs: ○ Yes, limited a lot ○ Yes, limited a little ○ No, not limited at all

During the **past week**, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like ○ Yes ○ No
5. Were limited in the kind of work or other activities ○ Yes ○ No

During the **past week**, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like? ○ Yes ○ No
7. Didn't do work or other activities as carefully as usual. ○ Yes ○ No
8. During the **past week**, how much did pain interfere with your normal work (including both work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with you **during the past week**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past week**...?

9. Have you felt calm and peaceful?

○ All of the time ○ Most of the time ○ A good bit of the time ○ Some of the time ○ A little of the time ○ None of the time

10. Did you have a lot of energy?

○ All of the time ○ Most of the time ○ A good bit of the time ○ Some of the time ○ A little of the time ○ None of the time

11. Have you felt downhearted and blue?

○ All of the time ○ Most of the time ○ A good bit of the time ○ Some of the time ○ A little of the time ○ None of the time

12. During the **past week**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

○ All of the time ○ Most of the time ○ A good bit of the time ○ Some of the time ○ A little of the time ○ None of the time

RAPID EATING ASSESSMENT FOR PATIENTS (REAP)

Please check the box that best describes your habits.

TOPIC	In an average week, how often do you:	Usually/ Often	Sometimes	Rarely/ Never	Does not apply to me
MEALS	1. Skip breakfast?	☐	☐	☐	
	2. Eat 4 or more meals from sit-down or take out restaurants?	☐	☐	☐	
GRAINS	3. Eat less than 3 servings of whole grain products a day? **Serving** = 1 slice of 100% whole grain bread; 1 cup whole grain cereal like Shredded Wheat, Wheaties, Grape Nuts, high fiber cereals, oatmeal, 3-4 whole grain crackers, ½ cup brown rice or whole wheat pasta	☐	☐	☐	
FRUITS & VEGETABLES	1. Eat less than 2-3 servings of fruit a day? **Serving** = ½ cup or 1 med. fruit or 4 oz. 100% fruit juice	☐	☐	☐	
	2. Eat less than 3-4 servings of vegetables/potatoes a day? **Serving** = ½ cup vegetables/potatoes, or 1 cup leafy raw vegetables	☐	☐	☐	
DAIRY	1. Eat or drink less than 2-3 servings of milk, yogurt, or cheese a day? **Serving** = 1 cup milk or yogurt; 1½ - 2 ounces cheese	☐	☐	☐	
	2. Use 2% (reduced fat) or whole milk instead of skim (non-fat) or 1% (low-fat) milk?	☐	☐	☐	Rarely use milk ☐
	3. Use regular cheese (like American, cheddar, Swiss, Monterey jack) instead of low fat or part skim cheeses as a snack, on sandwiches, pizza, etc?	☐	☐	☐	Rarely eat cheese
MEATS/CHICKEN/TURKEY	1. Eat beef, pork, or dark meat chicken more than 2 times a week?	☐	☐	☐	
	2. Eat more than 6 ounces (see sizes below) of meat, chicken, turkey or fish per day? ***Note**: 3 ounces of meat or chicken is the size of a deck of cards or ONE of the following: 1 regular hamburger, 1 chicken breast or leg (thigh & drumstick), or 1 pork chop.*	☐	☐	☐	Rarely eat meat, chicken, turkey or fish ☐
	3. Choose higher fat red meats like prime rib, T-bone steak, hamburger, ribs, etc. instead of lean red meats.	☐	☐	☐	Rarely eat meat ☐ Never eat meat, or poultry
	4. Eat the skin on chicken and turkey or the fat on meat?	☐	☐	☐	☐ Rarely eat processed meats
	5. Use regular processed meats (like bologna, salami, corned beef, hotdogs, sausage or bacon) instead of low-fat processed meats (like roast beef, turkey, lean ham; low-fat cold cuts/hotdogs)?	☐	☐	☐	
FRIED FOODS	14. Eat fried foods such as fried chicken, fried fish or French fries?	☐	☐	☐	

NEXT PAGE

TOPIC	In an average week, how often do you:	Usually/ Often	Sometimes	Rarely/ Never	Does not Apply to me
SNACKS	15. Eat regular potato chips, nacho chips, corn chips, crackers, regular popcorn, nuts instead of pretzels, low-fat chips or low-fat crackers, air-popped popcorn?	☐	☐	☐	Rarely eat these snack foods
FATS AND OILS	16. Use regular salad dressing & mayonnaise instead of low-fat or fat-free salad dressing and mayonnaise?	☐	☐	☐	Rarely use dressing/mayo
	17. Add butter, margarine or oil to bread, potatoes, rice or vegetables at the table?	☐	☐	☐	
	18. Cook with oil, butter or margarine instead of using non-stick sprays like Pam or cooking without fat?	☐	☐	☐	Rarely cook
SWEETS	19. Eat regular sweets like cake, cookies, pastries, donuts, muffins, and chocolate instead of low fat or fat-free sweets?	☐	☐	☐	Rarely eat sweets ☐
	20. Eat regular ice cream instead of sherbet, sorbet, low fat or fat-free ice cream, frozen yogurt, etc.?	☐	☐	☐	Rarely eat frozen desserts ☐
	21. Eat sweets like cake, cookies, pastries, donuts, muffins, chocolate and candies more than 2 times per day.	☐	☐	☐	Rarely eat sweets
SOFT DRINKS	22. Drink 16 ounces or more of non-diet soda, fruit drink/punch or Kool-Aid a day? ***Note*:** 1 can of soda = 12 ounces	☐	☐	☐	
SODIUM	23. Eat high sodium processed foods like canned soup or pasta, frozen/packaged meals (TV dinners, etc.), chips?	☐	☐	☐	
	24. Add salt to foods during cooking or at the table?	☐	☐	☐	
ALCOHOL	25. Drink more than 1-2 alcoholic drinks a day? (One drink = 12 oz. beer, 5 oz. Wine, one shot of hard liquor or mixed drink with 1 shot)	☐	☐	☐	
ACTIVITY	26. Do less than 30 total minutes of physical activity 3 days a week or more? (Examples: walking briskly, gardening, golf, jogging, swimming, biking, dancing, etc.)	☐	☐	☐	
	27. Watch more than 2 hours of television or videos a day?	☐	☐	☐	

Do you….	Yes	No
28. Usually shop and prepare your own food?	☐	☐
29. Ever have trouble being able to shop or cook?	☐	☐
30. Follow a special diet, eat, or limit certain foods for health or other reasons?	☐	☐

31. **How willing are you to make changes in what, how or how much you eat in order to eat healthier? (Check the number that best describes how you feel)**

Very willing				Not at all willing
5	4	3	2	1
☐	☐	☐	☐	☐

INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise, or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal.
Think only about those physical activities that you did for at least 10 minutes at a time.

1. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

   _____days per week

   ☐ No vigorous physical activities → **Skip to question 3**

2. How much time did you usually spend doing **vigorous** physical activities on one of those days?

   _____hours per day

   _____minutes per day

   ☐ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

   _____days per week

   ☐ No moderate physical activities → **Skip to question 5**

4. How much time did you usually spend doing **moderate** physical activities on one of those days?

   _____hours per day

   _____minutes per day

   ☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

_____days per week

☐ No walking → **Skip to question 7**

6. How much time did you usually spend **walking** on one of those days?

_____hours per day

_____minutes per day

☐ Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** on a **weekday**?

_____hours per day

_____minutes per day

☐ Don't know/Not sure

SHORT LAST 7 DAYS SELF-ADMINISTERED version of the IPAQ. Revised August 2002

DUKE ACTIVITY QUESTIONNAIRE

	Yes, with no difficulty	Yes, but with some difficulty	No, I can't do this	Don't do this for other reasons
In the last month:				
1. Take care of yourself, that is, eating, dressing, bathing, and using the toilet?	○	○	○	○
2. Walk indoors, such as around your house?	○	○	○	○
3. Walk a block or two on level ground?	○	○	○	○
4. Climb a flight of stairs or walk up a hill?	○	○	○	○
5. Run a short distance?	○	○	○	○
6. Do light work around the house like dusting or washing dishes?	○	○	○	○
7. Do moderate work around the house like vacuuming, sweeping floors, carrying in groceries?	○	○	○	○
8. Do heavy work around the house like scrubbing floors, or lifting or moving heavy furniture?	○	○	○	○
9. Do yardwork like raking leaves, weeding, or pushing a power mower?	○	○	○	○
10. Have sexual relations?	○	○	○	○
11. Participate in moderate recreational activities, like golf, bowling, dancing, doubles tennis, or throwing baseball or football?	○	○	○	○
12. Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	○	○	○	○

PERCIEVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by marking *how often* you felt or thought a certain way.

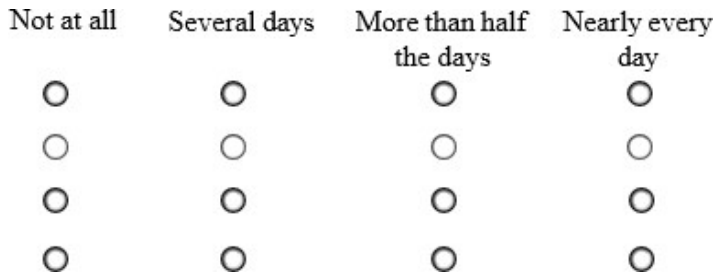
0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
2. In the last month, how often have you felt that you were unable to control the important things in your life?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
3. In the last month, how often have you felt nervous and "stressed?"	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
5. In the last month, how often have you felt that things were going your way?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
7. In the last month, how often have you been able to control irritations in your life?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
8. In the last month, how often have you felt that you were on top of things?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
9. In the last month, how often have you been angered because of things that were outside of your control?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	**0** ☐	**1** ☐	**2** ☐	**3** ☐	**4** ☐

References: The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. ***Journal of Health and Social Behavior, 24,*** **386-396.Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.)** ***The Social Psychology of Health. Newbury Park, CA: Sage, 1988.***

PHQ4 – ANXIETY & DEPRESSION SCALE

Over the **last 2 weeks** how often have you been bothered by the following problems?



SLEEP QUESTIONNAIRE

1. On average, how many hours of sleep do you get at night? _____
2. Please indicate the number of times per week over this last month that best describes how often you experienced the problems below. For example, place a "3" if it occurs on average 3 days per week, or a "0" if it does not occur in the average week.

   2.1. Have trouble falling asleep (# of days/week): _____

   2.2. Have difficulties going back to sleep after waking (# of days/week): _____

   2.3. Wake earlier than planned (# of days/week): _____

   2.4. Wake up several times a night (other than to feed baby) (# of days/week): _____

   2.5. Sleep was restless (# of days/week): _____

   2.6. Sleep aid (i.e., Ambien or melatonin) used to fall asleep (# of days/week): _____

      2.6.1. If you use sleep aids to fall asleep, please specify what you use: _____

3. Have you ever been diagnosed with Obstructive Sleep Apnea (OSA)? ☐ No ☐ Yes

   If yes, have you been prescribed OSA treatment? ☐ No ☐ Yes (CPAP) ☐ Yes (Mouthguard)

   If yes, do you regularly follow the treatment plan? ☐ No ☐ Yes

COVID-19 HISTORY

1. Since January 2020, have you had symptoms concerning of COVID-19 such as fever or chills, cough, fatigue, shortness of breath or difficulty breathing, headache, muscle or body aches, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, or new loss of taste or smell?

   ☐ No ☐ Yes

2. Since January 2020, have you received a probable or confirmed COVID-19 diagnosis?

   ☐ No ☐ Yes **(If no, skip to the next form)**

   2.1. If yes, how many times have you been diagnosed with COVID-19? _____

   2.2. Regarding your **FIRST** Covid-19 diagnosis:

      2.2.1. What month/year were you diagnosed? (mm/yyyy) _____

      2.2.2. Were you diagnosed because of:

      ☐ Positive test☐ symptoms with/without known close contact ☐ Both

      2.2.3. If you received a positive COVID-19 test, what type of test did you receive?

      ☐ PCR ☐ Antigen Rapid Test ☐ Positive Antibody Test ☐ Unknown

      2.2.4. Were you hospitalized because of this illness? ☐ No ☐ Yes

      2.2.5. Did you require treatment with (check all that apply)?

      ☐ Oxygen ☐ Steroids ☐ Antibiotics or antivirals (e.g. Remdesivir)

      ☐ Monoclonal Antibodies ☐ Other: _____

      2.2.6. Were you intubated? ☐ No ☐ Yes

2.2.7. Have you developed new chest pain or equivalent (chest tightness, arm pain, etc.) since your COVID-19 illness? ☐ No ☐ Yes If yes, please specify: _____

If you experienced chest pain or equivalent **prior to COVID-19**, has it worsened following your illness?
☐Not applicable (No chest pain prior) ☐ No ☐ Yes

2.3. Regarding your **SECOND** Covid-19 diagnosis (if applicable; if not, skip to question **#3**):

2.3.1. What month/year were you diagnosed? (mm/yyyy) _____

2.3.2. Were you diagnosed because of:

☐ Positive test ☐ symptoms with/without known close contact ☐ Both

2.3.3. If you received a positive COVID-19 test, what type of test did you receive?

☐ PCR ☐ Antigen Rapid Test ☐ Positive Antibody Test ☐ Unknown

2.3.4. Were you hospitalized because of this illness? ☐ No ☐ Yes

2.3.5. Did you require treatment with (check all that apply)?

☐ Oxygen ☐ Steroids ☐ Antibiotics or antivirals (e.g. Remdesivir)

☐ Monoclonal Antibodies ☐ Other: _____

2.3.6. Were you intubated? ☐ No ☐ Yes

2.3.7. Have you developed new chest pain or equivalent (chest tightness, arm pain, etc.) since your COVID-19 illness? ☐ No ☐ Yes If yes, please specify: _____

2.3.8. If you experienced chest pain or equivalent **prior to COVID-19**, has it worsened following your illness?
☐Not applicable (No chest pain prior) ☐ No ☐ Yes

3. Have you been diagnosed with a post-COVID condition, also known as long-COVID? ☐ No ☐ Yes

3.1. If yes, check which statement best describes your condition:

☐ My symptoms are noticeable but have no or little impact on my activities of daily living

☐ My symptoms have limited some of my activities of daily living

☐ My symptoms have severely limited or impaired my activities of daily living

3.2. If yes, please check which symptoms you have experienced:

☐ Tiredness or fatigue that interferes with daily life	☐ Symptoms that get worse after physical or mental effort	☐ Fast beating or pounding heart (heart palpitations)	☐ Difficulty breathing or shortness of breath
☐ Chest pain	☐ Cough	☐ Fever	☐ Headache
☐ Difficulty thinking or concentrating (brain fog)	☐ Sleep problems	☐ Dizziness when you stand up (lightheadedness)	☐ Pins-and-needles feelings
☐ Change in smell or taste	☐ Depression or anxiety	☐ Changes in menstrual cycles	☐ Stomach pain
☐ Diarrhea	☐ Joint or muscle pain	☐ Skin rash	☐ Other: _____

REPRODUCTIVE & PREGNANCY HISTORY

1) How old were you when you had your first menstrual period (menses)? _____

2) Have you ever been diagnosed with Polycystic Ovarian Syndrome or PCOS by a healthcare provider?

☐ No ☐ Yes If yes, at what age were you diagnosed? _____

3) Have you ever been diagnosed with Premenstrual Dysphoric Disorder (severe depression or anxiety before your menses)? ☐ No ☐ Yes If yes, at what age were you diagnosed? _____

4) Have you ever used birth control pills? ☐ No ☐ Yes, previously ☐ Yes, currently

4.1) At what age did you first start taking birth control pills? _____

4.2) At what age did you last stop taking birth control pills? (Leave blank if still on birth control) _____

4.3) How many total years and months did you take, or have you been taking, birth control pills?

_____years _____months

5) Have your natural periods stopped PERMANENTLY? ☐ No, I have menstrual periods

☐ Yes, I have no menstrual periods ☐ Yes, but I have periods induced by hormones

5.1) If yes, at what age did your natural periods stop? _____

5.2) If yes, why did your periods stop? ☐ They stopped naturally (menopause)

☐ Surgery to remove ovaries/uterus ☐ Endometrial ablation

☐ Radiation/chemotherapy ☐ Other _____

6) Have you had any of the following surgeries (check all that apply and age at time of surgery)?

☐ Removal of one ovary; age: _____ ☐ Removal of both ovaries; age: _____

☐ Hysterectomy; age: _____

7) Have you ever taken any type of hormonal replacement therapy (HRT)?

☐ No ☐ Yes, previously ☐ Yes, currently

7.1) If yes, indicate which one: ☐ Estrogen (Premarin, etc.) ☐ Progesterone (Provera, etc.)

☐ Testosterone ☐ Estrogen/Progesterone combo (Prempro, etc.) ☐ other: _____

7.2) If yes, age HRT started: _____ Age HRT stopped (leave blank if still on HRT): _____

8) Have you ever tried to become pregnant for more than 1 year without success? ☐ No ☐ Yes

8.1) If yes, what was the cause for not becoming pregnant?

☐ Unsure ☐ Medical issue with you

☐ Medical issue with partner ☐ Medical issue with both you and your partner

9) Have you ever used fertility treatments to assist in becoming pregnant? ☐ No ☐ Yes

9.1) If, yes, what treatment(s) have you received? ☐ Invitro Fertilization (IVF)

☐ Ovulation Induction (OI) / Intrauterine Insemination (IUI) ☐ Other: _____

10) Have you ever been pregnant (check all that apply)?

☐ Never Pregnant ☐ Currently Pregnant ☐ Previously Pregnant

If previously pregnant is selected, answer the following questions:

		Yes	No	If yes, how many?
10.a	Have you had any miscarriages?	☐	☐	_____
10.b	Have you had any tubal or ectopic pregnancies?	☐	☐	_____
10.c	Have you had any stillbirths (baby is born deceased)?	☐	☐	_____
10.d	Have you had any LIVE births (baby born alive)?	☐	☐	_____

11) Did you ever have any of these illnesses or complications during any of your pregnancies?

		Yes	No	If yes, # of pregnancies affected
11.a	High blood pressure first diagnosed during pregnancy?	☐	☐	_____
11.b	Pre-eclampsia or toxemia?	☐	☐	_____
11.c	Seizures, convulsions, or eclampsia?	☐	☐	_____
11.d	Diabetes first diagnosed during pregnancy?	☐	☐	_____
11.e	Liver damage, clotting issues, or HELLP during pregnancy?	☐	☐	_____
11.f	Birth of an infant weighing less than 5.5 lbs. (2.5 kgs)?	☐	☐	_____
11.g	Birth of a premature infant, or infant born before 37 weeks?	☐	☐	_____
11.h	Birth of multiples (e.g., twins, triplets, etc.)?	☐	☐	_____
11.i	Fetal Growth Restriction (FGR) / Intrauterine Grown Restriction (IUGR) / Small for gestational age (SGA)?	☐	☐	_____

Additional Complications (check all that apply):

11.j	Post-partum heart failure	☐
11.k	Arrythmias (Atrial Fibrillation, Palpitations, SVT etc.) during pregnancy	☐
11.l	Excessive blood loss or hemorrhage during pregnancy	☐
11.m	Low blood count or anemia during pregnancy	☐
11.n	Baby presentation feet/buttock first or breech birth	☐
11.o	Vascular complications w/ placenta	☐
11.p	Placenta covers cervix or placenta previa	☐
11.q	Any other complications with newborn	☐

Other Complications: _____

DEMOGRAPHIC INFORMATION

Demographic Information is optional; however, we encourage you to answer as we try to better understand how social determinants of health affect the heart and outcomes. It is the mission of the Women's Heart Center to bridge the gap in cardiovascular care and outcomes for women, minorities, and underrepresented populations.

1. Total family income (before taxes) from all sources within her household in the last year? (Mark the one that is the best guess).

☐ Less than $20,000 ☐ $20,000 to $34,999 ☐ $35,000 to $49,999

☐ $50,000 to $99,000 ☐ $100,000 or more ☐ Don't know

2. What is the highest level of school you have completed or the highest degree you have received?

☐ Never attended

☐ 1st Grade ☐ 2nd Grade ☐ 3rd Grade ☐ 4th Grade ☐ 5th Grade ☐ 6th grade

☐ 7th Grade ☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade

☐ High School Graduate ☐ GED or equivalent ☐ Some college, no degree

☐ Associate Degree (occupational, technical, vocational program)

☐ Associate Degree (academic program)

☐ Bachelor's Degree (BA, BS, etc.)

☐ Master's Degree (MA, MS, MEng, MEd, MSW, MBA, etc.)

☐ Professional School (MD, DDS, JD, DVM, etc.)

☐ Doctorate (PhD)

3. What is your job/occupation (current or prior to your retirement)? _____

MRN: _____