

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 one 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? <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Fatigue		
Please Select YES or NO for the following questions:	YES	NO
2. Are you able to exercise vigorously without chest pain, shortness of breath, or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you perform all your usual activities at a normal pace, climb one flight of stairs, or walk one block without experiencing chest pain, shortness of breath, or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have chest pain, shortness of breath, or fatigue at rest or with minimal activity?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you having random or sporadic chest pain at rest?	<input type="checkbox"/>	<input type="checkbox"/>

IF you answered YES to question 6 above, please answer ALL questions below. Complete Questions 7 - 16 IF you experienced random/at rest chest pain in the last month.

7. Over the last month, how often did you experience random/at rest chest pain? (Check One)

- Daily Weekly Monthly

- **IF DAILY:** On average, how many **total episodes per day?** _____
- **IF WEEKLY:** On average, how many **total episodes per week?** _____
- **IF MONTHLY:** On average, how many **total episodes per month?** _____

While answering the questions below, please remember, 1 = Least Severe, 10 = Most Severe

8. On a scale of 1 to 10, how would you rate the average intensity of your random/at rest chest pain? ____ / 10

9. On a scale of 1 to 10, how would you rate the most severe of your random/at rest chest pain? ____ / 10

10. Over the last month, how often did you experience random/at rest chest pain that you would classify as "severe" (based on Question 9)? **Please check frequency:** Daily Weekly Monthly

- **IF DAILY:** On average, how many **total episodes per day?** _____
- **IF WEEKLY:** On average, how many **total episodes per week?** _____
- **IF MONTHLY:** On average, how many **total episodes per month?** _____

11. What is the average duration of each episode of random/at rest chest pain? (Circle One)

- < 30 seconds 1 – 5 minutes 10 – 30 minutes
 30 – 60 seconds 5 – 10 minutes 30 – 60 minutes
 > 1 hour

12. Have you used sublingual nitroglycerin tablets/spray in the last month? Yes No Not Prescribed

- **IF YES:** On average, how many random/at rest chest pain episodes did you use Nitro for? _____
- On average, how many Nitro doses did you take per episode? _____
- On average, at what pain level (1 – 10) do you take Nitro? ____ / 10
- Is your random/at rest chest pain responsive to Nitro (i.e., pain reduces or resolves)? Yes No

13. What time of day do you typically experience random/at rest chest pain? (Check ALL that apply)

- Overnight (12:00am – 6:00am) Afternoon (12:00pm – 6:00pm)
 Morning (6:00am – 9:00am) Evening (6:00pm – 9:00pm)
 Late Morning (9:00am – 12:00pm) Nighttime (9:00pm – 12:00am)

14. Does random/at rest chest pain ever wake you up from sleep? Yes No

15. Do you experience any of the following accompanying symptoms with random/at rest chest pain?

(Check ALL that apply)

- Nausea or Vomiting Abdominal Pain Arm Pain
 Diaphoresis (Sweating) Jaw Pain Shortness of Breath

16. Do any of the following trigger a random/at rest chest pain episode? (Check ALL that apply)

- Stress Anxiety
 Fear or Being Startled Crying
 Anger/Frustration Bad Dreams
 Feeling Short of Breath/Hyperventilation Migraine
 Hot/Cold Weather

THE SEATTLE ANGINA 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	<input type="checkbox"/>					
Walking indoors on level ground	<input type="checkbox"/>					
Showering	<input type="checkbox"/>					
Climbing a hill or a flight of stairs without stopping	<input type="checkbox"/>					
Gardening, Vacuuming, or carrying groceries	<input type="checkbox"/>					
Walking more than a block at a brisk pace	<input type="checkbox"/>					
Running or jogging	<input type="checkbox"/>					
Lifting or moving heavy objects (e.g. furniture, children)	<input type="checkbox"/>					
Participating in Strenuous sports (e.g. swimming, tennis)	<input type="checkbox"/>					

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 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

How much do these limit you in your daily life?

- | | | | | | | | | | | | | |
|---|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|
| 22. Shortness of breath..... | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> | 5 | <input type="checkbox"/> |
| 23. Fear of "hurting myself" by overexerting..... | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> | 5 | <input type="checkbox"/> |
| 24. Fear of shortness of breath..... | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> | 5 | <input type="checkbox"/> |

HEALTH-RELATED QUALITY OF LIFE ASSESSMENT TOOL(EQ-5D-5L)

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

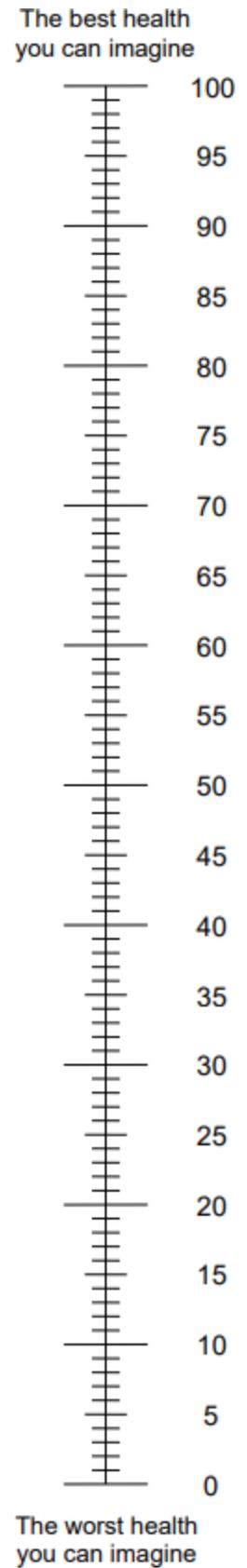
- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I am extreme pain or discomfort

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 =



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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	2. Eat 4 or more meals from sit-down or take out restaurants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FRUITS & VEGETABLES	4. Eat less than 2-3 servings of fruit a day? Serving = ½ cup or 1 med. fruit or 4 oz. 100% fruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	5. Eat less than 3-4 servings of vegetables/potatoes a day? Serving = ½ cup vegetables/potatoes, or 1 cup leafy raw vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY	6. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely use milk <input type="checkbox"/>
	7. Use 2% (reduced fat) or whole milk instead of skim (non-fat) or 1% (low-fat) milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely eat cheese <input type="checkbox"/>
	8. Use regular cheese (like American, cheddar, Swiss, Monterey jack) instead of low fat or part skim cheeses as a snack, on sandwiches, pizza, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEATS/CHICKEN/TURKEY	9. Eat beef, pork, or dark meat chicken more than 2 times a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely eat meat, chicken, turkey or fish <input type="checkbox"/>
	10. 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely eat meat <input type="checkbox"/>
	11. Choose higher fat red meats like prime rib, T-bone steak, hamburger, ribs, etc. instead of lean red meats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never eat meat or poultry <input type="checkbox"/>
	12. Eat the skin on chicken and turkey or the fat on meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	13. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely eat processed meats <input type="checkbox"/>
FRIED FOODS	14. Eat fried foods such as fried chicken, fried fish or French fries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely eat these snack foods <input type="checkbox"/>
FATS AND OILS	16. Use regular salad dressing & mayonnaise instead of low-fat or fat-free salad dressing and mayonnaise? 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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rarely use dressing/mayo <input type="checkbox"/> Rarely cook <input type="checkbox"/>
SWEETS	19. Eat regular sweets like cake, cookies, pastries, donuts, muffins, and chocolate instead of low fat or fat-free sweets? 20. Eat regular ice cream instead of sherbet, sorbet, low fat or fat-free ice cream, frozen yogurt, etc.? 21. Eat sweets like cake, cookies, pastries, donuts, muffins, chocolate and candies more than 2 times per day.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rarely eat sweets <input type="checkbox"/> Rarely eat frozen desserts <input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rarely drink soft drinks <input type="checkbox"/>
SODIUM	23. Eat high sodium processed foods like canned soup or pasta, frozen/package meals (TV dinners, etc.), chips? 24. Add salt to foods during cooking or at the table?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Do you....	Yes	No
28. Usually shop and prepare your own food?	<input type="checkbox"/>	<input type="checkbox"/>
29. Ever have trouble being able to shop or cook?	<input type="checkbox"/>	<input type="checkbox"/>
30. Follow a special diet, eat, or limit certain foods for health or other reasons?	<input type="checkbox"/>	<input type="checkbox"/>
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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DUKE ACTIVITY STATUS INDEX

	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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Walk indoors, such as around your house? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Walk a block or two on level ground? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Climb a flight of stairs or walk up a hill? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Run a short distance? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do light work around the house like dusting or washing dishes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do moderate work around the house like vacuuming, sweeping floors, carrying in groceries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do heavy work around the house like scrubbing floors, or lifting or moving heavy furniture? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do yardwork like raking leaves, weeding, or pushing a power mower? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have sexual relations? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Participate in moderate recreational activities, like golf, bowling, dancing, doubles tennis, or throwing baseball or football? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Hlatky MA, Boineau RE, Higginbotham MB, Lee KL, Mark DB, Califf RM, Cobb FR, Pryor DB. A brief self-administered questionnaire to determine functional capacity (the Duke Activity Status Index). Am J Cardiol. 1989 Sep 15;64(10):651-4. doi: 10.1016/0002-9149(89)90496-7. PMID: 2782256.

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

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.

PATIENT HEALTH QUESTIONNAIRE - 8 (PHQ - 8)

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

(Circle the number that corresponds to your answer)	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
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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute

PITTSBURGH SLEEP QUALITY INDEX

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you . . .

- a) Cannot get to sleep within 30 minutes

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- b) Wake up in the middle of the night or early morning

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- c) Have to get up to use the bathroom

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- d) Cannot breathe comfortably

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- e) Cough or snore loudly

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- f) Feel too cold

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

- g) Feel too hot

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____
------------------------------------	--------------------------------	-------------------------------	-------------------------------------

h) Had bad dreams

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

i) Have pain

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

j) Other reason(s), please describe _____

How often during the past month have you had trouble sleeping because of this?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

6. During the past month, how would you rate your sleep quality overall?

Very good _____ Fairly good _____ Fairly bad _____ Very bad _____

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all _____
Somewhat of a problem _____
Only a very slight problem _____
A very big problem _____

10. Do you have a bed partner or room mate?

No bed partner or room mate _____
Partner in same room, but not same bed _____
Partner/room mate in other room _____
Partner in same bed _____

If you have a room mate or bed partner, ask him/her how often in the past month you have had...

a) Loud snoring

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

b) Long pauses between breaths while asleep

Not during the past month _____ Less than once a week _____ Once or twice a week _____ Three or more times a week _____

c) Legs twitching or jerking while you sleep

Not during the
past month _____

Less than
once a week _____

Once or twice
a week _____

Three or more
times a week _____

d) Episodes of disorientation or confusion during sleep

Not during the
past month _____

Less than
once a week _____

Once or twice
a week _____

Three or more
times a week _____

e) Other restlessness while you sleep; please describe _____

Not during the
past month _____

Less than
once a week _____

Once or twice
a week _____

Three or more
times a week _____

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FAMILY HISTORY OF Coronary Microvascular and Vasomotor Dysfunction

1. Do you have any **BLOOD RELATIVES** (parents, siblings, children, or extended biological family such as grandparents, aunts, uncles, or cousins) who have been diagnosed with any of the following?

[Check all that apply]

No

Not Sure

ANOCA (Angina with No Obstructive Coronary Arteries)

INOCA (Ischemia with No Obstructive Coronary Arteries)

MINOCA (Myocardial Infarction with No Obstructive Coronary Arteries)

CMD (Coronary Microvascular Dysfunction)

Coronary Vasospasm

2. If you checked "yes" to #2 above, are your **BLOOD RELATIVES** with these conditions/symptoms listed above a patient of Dr. Odayme Quesada, Dr. Timothy Henry, Dr. Shree Lata Radhakrishnan, Julie Henry, NP Tammy Trenaman, NP or Darlene Tierney, NP?

Check One: Yes No

3. Do you have any **BLOOD RELATIVES** who experience chest pain or symptoms similar to yours, but have NOT been diagnosed with a heart condition?

Check One: Yes No Not Sure

COVID-19 HISTORY

1. Since January 2020, have you had symptoms concerning 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? _____
3. Have you developed new chest pain or equivalent (chest tightness, arm pain, etc.) since your COVID-19 illness? No Yes
4. If you experienced chest pain or equivalent **prior to COVID-19**, has it worsened following your illness? No Yes
5. Have you been diagnosed with a post-COVID condition, also known as long-COVID? No Yes
 - 5.1 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
 - 5.2 If yes, please check which symptoms you have experienced:
 - Tiredness or fatigue that interferes with daily life
 - Chest Pain
 - Difficulty thinking or concentrating (brain fog)
 - Change in smell or taste
 - Diarrhea
 - Symptoms that get worse after physical or mental effort
 - Cough
 - Sleep Problems
 - Depression or anxiety
 - Joint or muscle pain
 - Fast beating or pounding heart (heart palpitations)
 - Fever
 - Dizziness when you stand up (lightheadedness)
 - Change in menstrual cycles
 - Skin rash
 - Difficulty breathing or shortness of breath
 - Headache
 - Pins-and-needles feelings
 - Stomach pain
 - Other: _____

REPRODUCTIVE & PREGNANCY HISTORY

MENSTRUAL HISTORY

1. How old were you when you had your first menstrual period (menses)? _____
2. Have your natural periods stopped PERMANENTLY (menopause = no periods for 12 months)?
 No, I have menstrual periods
IF NO, skip to question 5
 Yes, I have not had menstrual periods
for more than 12 months
3. **IF YES**, how did your periods stop?
 Naturally at age: _____ (Year: _____)
 Surgically/Medically at age: _____ (Year: _____)
If surgically/medically stopped, age of menopause (if different from age of surgery): _____ (Year: _____)
4. **IF YES**, have you ever or are you currently experiencing any of the following vasomotor symptoms during menopause? (Check ALL that apply)
 Hot flashes (hot flushes) Heart palpitations
 Night sweats Increased perspiration
 Flushing or reddening of the skin Sleep disturbances (due to night sweats)
 Sudden feeling of warmth Dizziness or lightheadedness
 Chills or shivering following a hot flash Anxiety or irritability
5. Have you ever been diagnosed with **Polycystic Ovarian Syndrome (PCOS)** by a healthcare provider?
 No Yes **IF YES**, at what age were you diagnosed? _____
6. Have you ever been diagnosed with **Premenstrual Dysphoric Disease (PMDD)** (severe depression/ anxiety before your menses)? No Yes **IF YES**, at what age were you diagnosed? _____
7. Have you used hormonal birth control pills/medication? No Yes
7.1 **IF YES**, at what age did you first start taking birth control? _____
7.2 At what age did you last stop taking birth control pills? _____ (Leave blank if still on birth control)
7.3 How many total years and months did you take/have you been taking birth control pills? _____
8. Have you had any of the following surgeries (Check ALL that apply and age at time of surgery)?
 Removal of one ovary: Age: _____, Year: _____
 Removal of both ovaries: Age: _____, Year: _____
 Hysterectomy: Age: _____, Year: _____
9. Have you ever taken any type of Menopausal Hormone Therapy (MHT)? No Yes Yes, currently
9.1 **IF YES**, indicate which one(s):
 Estrogen (e.g., patch, premarin, vaginal cream, etc.)
 Progesterone (Provera, etc.)
 Estrogen/Progesterone Combo (Prempro, etc.)
 Testosterone
 Other: _____
9.2 **IF YES**, age MHT started: _____
9.3 Age MHT stopped (leave blank if still on MHT): _____

PREGNANCY HISTORY

10. Have you ever used fertility treatments to assist in becoming pregnant? No Yes

11. **IF YES**, what treatment(s) have you received?

In vitro Fertilization (IVF)

Ovulation Induction (OI)/Intrauterine Insemination (IUI)

Other: _____

12. Have you ever been pregnant (Check ALL that apply)

Never Pregnant

Currently Pregnant

Previously Pregnant

If previously pregnant was selected, please answer the following questions:

13. How many times have you been pregnant? _____

14. How many LIVE births (baby born alive)? _____

15. Did you ever have any of the following illnesses or complications during any of your pregnancies?

		YES	NO	IF YES, # of pregnancies affected
15.1	High blood pressure first diagnosed during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
15.2	Pre-eclampsia or toxemia?	<input type="checkbox"/>	<input type="checkbox"/>	
15.3	Seizures, convulsions, or eclampsia?	<input type="checkbox"/>	<input type="checkbox"/>	
15.4	Diabetes first diagnosed during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
15.5	Liver damage, clotting issues, or HELLP during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
15.6	Birth of an infant weighting less than 5.5 lbs. (2.5 kgs)?	<input type="checkbox"/>	<input type="checkbox"/>	
15.7	Birth of a premature infant, or infant born before 37 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
15.8	Birth of multiples (i.e., twins, triplets, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	
15.9	Fetal Growth Restriction (FGR)/Intrauterine Growth Restriction (IUGR)/Small for gestational age (SGA)?	<input type="checkbox"/>	<input type="checkbox"/>	

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

(Check ALL that apply)

15.10	Post-partum heart failure	<input type="checkbox"/>
15.11	Arrhythmias (Atrial Fibrillation, Palpitations, SVT, etc.) during pregnancy	<input type="checkbox"/>
15.12	Excessive blood loss or hemorrhage during pregnancy	<input type="checkbox"/>
15.13	Low blood count or anemia during pregnancy	<input type="checkbox"/>
15.14	Baby presentation feet/buttock first or breech birth	<input type="checkbox"/>
15.15	Vascular complications w/ placenta	<input type="checkbox"/>
15.16	Placenta covers cervix or placenta previa	<input type="checkbox"/>
15.17	Complications with newborn	<input type="checkbox"/>
15.18	Other complications	<input type="checkbox"/>

HEADACHE & MIGRAINE

1. Have you experienced headaches? Yes No
2. Does light bother you when you have a headache? Yes No
3. Has a headache limited your ability to work, study, or do what you needed to do? Yes No
4. Have you felt nauseated or sick to your stomach during a headache? Yes No

If you answered YES to any of the questions above, please continue below.

Headache History

5. At what age do you think the headaches began? _____ years

BEFORE YOUR HEADACHE:

6. Do you experience any of the following BEFORE the headache starts? (Check ALL that apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Tired | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Food Cravings |
| <input type="checkbox"/> Sunken Eyes | <input type="checkbox"/> Yawning |
| <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Other |
| <input type="checkbox"/> "Not right" | |

7. Triggers that can start a headache (Check ALL that apply)

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Skipping Meals | <input type="checkbox"/> Smells |
| <input type="checkbox"/> Noises | <input type="checkbox"/> Menstruation | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Too much/little sleep | <input type="checkbox"/> Light |
| <input type="checkbox"/> Food | <input type="checkbox"/> Hunger | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Sexual Activity | |

AURAS:

8. Are there any warning signs that a headache is going to start? (Check ALL that apply)

- | | |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Visual | <input type="checkbox"/> Taste |
| <input type="checkbox"/> Auditory | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Sensory | <input type="checkbox"/> Other |
| <input type="checkbox"/> Smell | |

DURING HEADACHE:

9. Where does the headache typically occur? (Check ALL that apply)

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side | <input type="checkbox"/> Back |
| <input type="checkbox"/> Left side | <input type="checkbox"/> Around eyes |
| <input type="checkbox"/> Front | <input type="checkbox"/> Behind eyes |
| <input type="checkbox"/> Top | <input type="checkbox"/> All over |

10. Symptoms during a headache (Check ALL that apply)

- | | |
|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Redness of face | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Sensitivity to sound | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Appetite loss | <input type="checkbox"/> Trouble with thinking/walking/speech |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Tearing eyes | <input type="checkbox"/> Double vision |
| | <input type="checkbox"/> Other _____ |

11. Describe the pain (Check ALL that apply)

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Crushing |
| <input type="checkbox"/> Squeezing | <input type="checkbox"/> Pinching |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Constant |
| <input type="checkbox"/> "There" | <input type="checkbox"/> Other _____ |

SEVERITY & FREQUENCY

12. Average duration of headache without treatment: _____ hours

13. Average severity: Mild Moderate Severe

14. Rate Pain (0 – 10): _____

15. Headache frequency: _____ days/month _____ days/year

HEADACHE EFFECTS

16. Is it worsened by activity/exercise? Yes No N/A

17. Is it improved with rest or sleep? Yes No N/A

18. List all medications taken for headaches/migraines

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

DEMOGRAPHIC INFORMATION

The following 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 is to bridge the gap in cardiovascular care and outcomes for women, minorities, and underrepresented populations.

1. Gender Identity

- Male
- Female
- Transgender Female (Male-to-Female)
- Transgender Male (Female-to-Male)
- Other
- Choose not to disclose

2. Legal Sex

- Male
- Female
- Unknown

3. Sex assigned at birth

- Male
- Female
- Unknown
- Not recorded on birth certificate
- Uncertain
- Choose not to disclose

4. Marital Status

- Divorced
- Life partner
- Married
- Separated
- Significant other
- Single
- Unknown
- Widowed
- Choose not to disclose

5. Race

- American Indian / Alaskan Native
- Asian
- Black / African American
- Declined
- Native Hawaiian / Other Pacific Islander
- Unknown / Unavailable
- White / Caucasian
- Choose not to disclose

6. Ethnicity

- Hispanic
- Non-Hispanic
- Not reported / Unknown
- Choose not to disclose

7. Preferred Language

- English
- Spanish
- Other

If other, please specify what language

8. Zip Code _____

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

- | | |
|--|--|
| <input type="checkbox"/> Never attended school | <input type="checkbox"/> GED or equivalent |
| <input type="checkbox"/> 1st - 5th grade | <input type="checkbox"/> Some college, no degree |
| <input type="checkbox"/> 6th - 8th grade | <input type="checkbox"/> Associate Degree: academic program |
| <input type="checkbox"/> 9th grade | <input type="checkbox"/> Associate Degree: occupational, technical, or vocational program |
| <input type="checkbox"/> 10th grade | <input type="checkbox"/> Bachelor's Degree (e.g. BA, AB, BS) |
| <input type="checkbox"/> 11th grade | <input type="checkbox"/> Master's Degree (e.g. MA, MS, Mend, Med, MSW, MBA) |
| <input type="checkbox"/> 12th grade | <input type="checkbox"/> Doctorate / Professional degree (e.g., PhD, MD, DO, DDS, DMV, JD, etc.) |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Choose not to disclose |

10. What is your job /occupation?

11. Total household 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 \$30,000
- \$35,000 to \$49,999
- \$50,000 to \$99,000
- \$100,000 or more
- Don't know
- Choose not to disclose

12. Which category best describes your method of reimbursement for health care?

- Medicare
- Other public (includes Medicaid, CHAMPUS, Administar Defense, etc.)
- Private/Commercial Insurance (includes fee for services, HMO, PPO)
- None / selfpay