The Christ Hospital Health Network
Women's Heart Center

WHC & CMVD Program
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 and is also home to the gender-neutral Coronary Microvascular & Vasomotor Dysfunction (CMVD) Program. 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, FESC
Medical Director, The Christ Hospital Women's Heart Center

IMPORTANT

Over the past 4 weeks, have you experienced any chest pain, chest tightness, or shortness of breath either with activity (exertion) or while at rest (random)?

❍ **No. If NO, SKIP to page 6 - Health Related Quality of Life Assessment.**

❍ **Yes,** I have experienced chest pain, chest tightness, or shortness of breath over the past 4 weeks. **If YES,** please continue.

ANGINA CLASS QUESTIONS

1. Which symptom, if any, do you predominantly feel?
   ☐ Chest Pain ☐ Shortness of Breath ☐ 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?	☐	☐
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?	☐	☐
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?	☐	☐
5. Do you have chest pain, shortness of breath, or fatigue at rest or with minimal activity?	☐	☐
6. Are you having random or sporadic chest pain at rest?	☐	☐

IMPORTANT

IF you answered YES to question 6 above, please answer questions 7 - 16 below.
If you answered NO to question 6, skip to the next page.

VASOSPASTIC ANGINA QUESTIONNAIRE

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 <u>over the past 4 weeks.</u>**

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. <u>Compared with 4 weeks ago</u>, 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
☐	☐	☐	☐	☐	☐

3. Over the <u>past 4 weeks</u>, 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
☐	☐	☐	☐	☐	☐

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

IMPORTANT

If you have not experienced any shortness of breath over the last 4 weeks, skip to the next form/page.

If you have experienced any shortness of breath over the last 4 weeks, 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 ☐

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

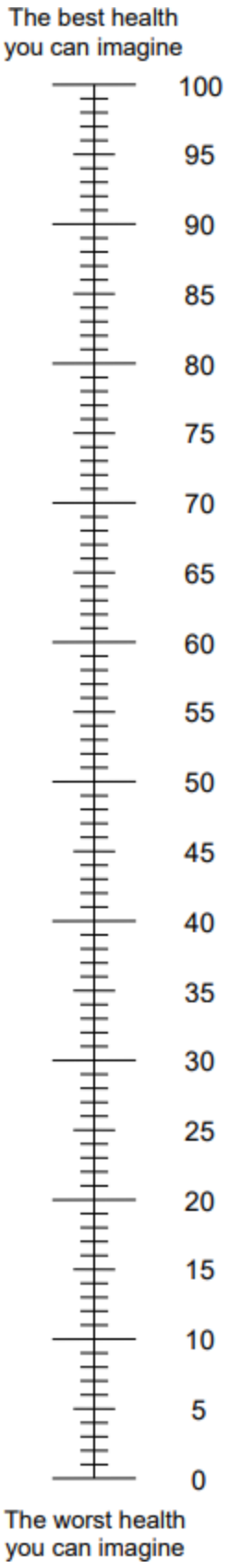
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I am extreme pain or discomfort ☐

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?	☐	☐	☐	
	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	4. Eat less than 2-3 servings of fruit a day? **Serving** = ½ cup or 1 med. fruit or 4 oz. 100% fruit juice	☐	☐	☐	
	5. Eat less than 3-4 servings of vegetables/potatoes a day? **Serving** = ½ cup vegetables/potatoes, or 1 cup leafy raw vegetables	☐	☐	☐	
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	☐	☐	☐	Rarely use milk ☐
	7. Use 2% (reduced fat) or whole milk instead of skim (non- fat) or 1% (low-fat) milk?	☐	☐	☐	Rarely eat cheese ☐
	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?	☐	☐	☐	
MEATS/CHICKEN/TURKEY	9. Eat beef, pork, or dark meat chicken more than 2 times a week?	☐	☐	☐	Rarely eat meat, chicken, turkey or fish ☐
	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.*	☐	☐	☐	Rarely eat meat ☐
	11. Choose higher fat red meats like prime rib, T-bone steak, hamburger, ribs, etc. instead of lean red meats.	☐	☐	☐	Never eat meat or poultry ☐
	12. Eat the skin on chicken and turkey or the fat on meat?	☐	☐	☐	
	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)?	☐	☐	☐	Rarely eat processed meats ☐
FRIED FOODS	14. Eat fried foods such as fried chicken, fried fish or French fries?	☐	☐	☐	

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.	☐	☐	☐	
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	☐	☐	☐	Rarely drink soft drinks ☐
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
☐	☐	☐	☐	☐

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?	☐	☐	☐	☐
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?	☐	☐	☐	☐

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

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 <u>last 2 weeks</u>, 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 _____

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, sort 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

IMPORTANT

If your sex assigned at birth is male, skip to the next form on page 18.

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)
   ☐ Night sweats
   ☐ Flushing or reddening of the skin
   ☐ Sudden feeling of warmth
   ☐ Chills or shivering following a hot flash
   ☐ Heart palpitations
   ☐ Increased perspiration
   ☐ Sleep disturbances (due to night sweats)
   ☐ Dizziness or lightheadedness
   ☐ 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?
    - ☐ Invitro 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?	☐	☐	
15.2	Pre-eclampsia or toxemia?	☐	☐	
15.3	Seizures, convulsions, or eclampsia?	☐	☐	
15.4	Diabetes first diagnosed during pregnancy?	☐	☐	
15.5	Liver damage, clotting issues, or HELLP during pregnancy?	☐	☐	
15.6	Birth of an infant weighting less than 5.5 lbs. (2.5 kgs)?	☐	☐	
15.7	Birth of a premature infant, or infant born before 37 weeks?	☐	☐	
15.8	Birth of multiples (i.e., twins, triplets, etc.)?	☐	☐	
15.9	Fetal Growth Restriction (FGR)/Intrauterine Grown Restriction (IUGR)/Small for gestational age (SGA)?	☐	☐	

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	☐
15.11	Arrythmias (Atrial Fibrillation, Palpitations, SVT, etc.) during pregnancy	☐
15.12	Excessive blood loss or hemorrhage during pregnancy	☐
15.13	Low blood count or anemia during pregnancy	☐
15.14	Baby presentation feet/buttock first or breech birth	☐
15.15	Vascular complications w/ placenta	☐
15.16	Placenta covers cervix or placenta previa	☐
15.17	Complications with newborn	☐
15.18	Other complications	☐

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.

IMPORTANT

If you answered NO to questions 1 - 4 above, skip to the Demographic Information form on page 20.

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)
   - ☐ Tired
   - ☐ Irritable
   - ☐ Sunken Eyes
   - ☐ Flushed Face
   - ☐ "Not right"
   - ☐ Mood Changes
   - ☐ Food Cravings
   - ☐ Yawning
   - ☐ Other

7. Triggers that can start a headache (Check ALL that apply)
   - ☐ Stress
   - ☐ Noises
   - ☐ Alcohol
   - ☐ Food
   - ☐ Weather
   - ☐ Chocolate
   - ☐ Skipping Meals
   - ☐ Menstruation
   - ☐ Too much/little sleep
   - ☐ Hunger
   - ☐ Pregnancy
   - ☐ Sexual Activity
   - ☐ Smells
   - ☐ Concentrating
   - ☐ Light
   - ☐ Caffeine
   - ☐ Other

AURAS:

8. Are there any warning signs that a headache is going to start? (Check ALL that apply)
   - ☐ Visual
   - ☐ Auditory
   - ☐ Sensory
   - ☐ Smell
   - ☐ Taste
   - ☐ Speech
   - ☐ Other

DURING HEADACHE:

9. Where does the headache typically occur? (Check ALL that apply)
   - ☐ Right side
   - ☐ Left side
   - ☐ Front
   - ☐ Top
   - ☐ Back
   - ☐ Around eyes
   - ☐ Behind eyes
   - ☐ All over

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

- ☐ Nausea
- ☐ Redness of face
- ☐ Runny nose
- ☐ Sensitivity to light
- ☐ Sensitivity to sound
- ☐ Appetite loss
- ☐ Sweating
- ☐ Tearing eyes
- ☐ Vomiting
- ☐ Fatigue
- ☐ Stomach pain
- ☐ Confusion
- ☐ Ringing in ears
- ☐ Trouble with thinking/walking/speech
- ☐ Lightheadedness
- ☐ Double vision
- ☐ Other _____

11. Describe the pain (Check ALL that apply)

- ☐ Throbbing
- ☐ Pressure
- ☐ Dull
- ☐ Squeeing
- ☐ Burning
- ☐ "There"
- ☐ Stabbing
- ☐ Sharp
- ☐ Crushing
- ☐ Pinching
- ☐ Constant
- ☐ 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. _____
2. _____
3. _____
4. _____
5. _____
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?

- ☐ Never attended school
- ☐ 1st - 5th grade
- ☐ 6th - 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ 12th grade
- ☐ High school graduate
- ☐ GED or equivalent
- ☐ Some college, no degree
- ☐ Associate Degree: academic program
- ☐ Associate Degree: occupational, technical, or vocational program
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, Mend, Med, MSW, MBA)
- ☐ Doctorate / Professional degree (e.g., PhD, MD, DO, DDS, DMV, JD, etc.)
- ☐ 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