Welcome to The Polyclinic Lipid Clinic!

We look forward to partnering together to lower your risk for cardiovascular events (heart attack/stroke) through lifestyle strategies and use of medications, if appropriate. We welcome patients with medication and diet sensitivities.

A provider will meet with you each visit to assess your cardiometabolic risk and help you set and achieve individual goals. Your primary/referring provider will receive a summary of our visit(s).

Your First Visit
Your first visit in the Lipid Clinic will last approximately 45 minutes. The provider will spend time talking about cardiovascular disease, diet, exercise/activity, as well as discuss your general health and medical history. Please complete the attached forms and bring them with you. This will help us make the most of your first visit. Your partner, other family members, and/or support person(s) are encouraged to come with you.

Your Appointments
Laboratory tests will be done at regular intervals to refine your treatment plan. The provider will provide recommendations and suggest adjustments to your medications or lifestyle. At each visit, you will choose self-management goals to direct your care. The frequency of your appointments will depend on your individual risk and treatment plan.

Questions?
If you have questions or need information about the Lipid Clinic, please call (206) 860-4669.

Sincerely,

Jessica Durham, ARNP, CLS, FNLA

Katherine Parikh, ARNP

Locations
Northgate Plaza (M, W, F) 9709 3rd Ave NE, 3rd floor
Seattle, WA 98115

Madison Center (M-F) 904 7th Ave, 7th floor
Seattle, WA 98104
Lipid Clinic

Name ______________________ DOB ____/_____/_____ Date ___________________
Primary Care Provider ______________ Cardiologist ______________ Endocrinologist _______________

Allergies to medications (please include reaction)

Marital Status (Please circle)
Single   Married   Partner   Divorced   Widowed

Occupation ______________________

“Typical Day” Activity at Work
Check most appropriate – defer if retired
☐ Minimal – Desk most of the day
☐ Moderate – Walking most of the day
☐ Intense – Jogging/cycling most of the day

“Typical Day” Activity at Work
Please include length of time & how often:
Walking/running ______________________
Gardening ______________________
Cycling ______________________
Swimming ______________________
Other ______________________

“Typical Week” Physical Activity Habits
Please include length of time & how often:
Walking/running ______________________
Gardening ______________________
Cycling ______________________
Swimming ______________________
Other ______________________

“Typical Week” Physical Activity Habits
Please include length of time & how often:

“Typical Day” Dietary Intake
Please list the types of foods:
Breakfast ______________________
Lunch ______________________
Dinner ______________________
Snacks ______________________

“Typical Day” Dietary Intake
Please list the types of foods:

Smoking/Chewing Tobacco History
Please circle: cigarettes   pipe   cigars
chewing tobacco   marijuana   e-cigarettes
☐ Never
☐ Occasional ___ /year
☐ Used x ___ years, Quit ___ years ago, Qty:____
☐ Quit x ______, Restarted & currently ____/day
☐ Currently ____/day for ____ years

Alcohol Intake
Please quantify drinks:
☐ Never
☐ Occasional ____/ year
☐ Monthly ____/ month
☐ Weekly ____/week
Type of drinks: ______________________

Water Intake: ____ oz daily

Family History
Please obtain as much information as possible, focusing on High Cholesterol, Diabetes, and Heart Problems with their ages of occurrence:
Mother ______________________
Father ______________________
Sibling ______________________
Sibling ______________________
Sibling ______________________
Grandparent ______________________
Grandparent ______________________

What are you most concerned about?
☐ Having a Heart Attack
☐ Having a Stroke
☐ Liver Problems
☐ Other ______________________

Have you had problems with cholesterol lowering medications in the past? ☐ Yes ☐ No
If yes, please list medication(s) and reaction(s): ______________________

Educational Level (Please circle highest level)
Grade   High   Vocational   College

Do you have any physical limitations? ☐ Yes ☐ No
Current Medications & Dosages

Do you take supplements?  □ Yes  □ No

If yes, please list:

Please list any areas you would like to focus on or concerns that you have pertaining to your cardiovascular risk:

How often do you get dental cleanings?  (Please circle for next 5 questions)
<1x/year  1x/year  2x/year  3x/year

Date of last cleaning: ___________

Do you use an electric rechargeable toothbrush?  Yes  No

How often do you brush your teeth?  How often do you floss your teeth?
<1x day  1x/day  2x/day  3x/day  Never  Monthly or as needed  Couple times a week  Daily

Do your gums bleed with either of the above?  Yes  No

Past Medical History  Please check all that apply & your age when diagnosed/occurred:

□ Pancreatitis ______
□ High Cholesterol ______
□ High Blood Pressure ______
□ Heart Attack ______
□ Heart Problems ______
□ Stroke ______
□ Diabetes ______
□ Aortic Aneurysm ______
□ Kidney Problems ______
□ Liver Problems ______
□ Poor blood flow to extremities ______
□ Thyroid Problems ______
□ Rheumatoid Arthritis ______
□ Lupus ______
□ Psoriasis ______
□ Migraines with Aura ______

□ Polycystic Ovarian Syndrome ______
□ Schizophrenia ______
□ Gout ______
□ Osteoporosis ______
□ Obstructive Sleep Apnea ______
□ Snoring, headache, and daytime tiredness ______
□ Numbness, tingling, burning in hands and/or feet ______
□ Fatty Liver ______
□ Gestational Diabetes ______
□ Pre-eclampsia ______
□ Pre-term labor (<37 weeks) ______
□ H. Pylori Infection ______
□ Erectile Dysfunction ______
□ Periodontal Disease ______
□ Breast Cancer survivor ______

If yes, □ radiation  □ chemo

How would you rate your current health?
□ Excellent  □ Good  □ Fair  □ Poor

How many hours a night do you sleep? ______

Do you feel well rested?  □ Yes  □ No  □ Depends

How would you rate your current diet?
□ Excellent  □ Good  □ Fair  □ Poor

Do you enjoy using the internet?  □ Yes  □ No

How many hours a day do you spend in front of a screen?
<1  2-4  5-8  >8

Are you satisfied with your weight?
□ Yes  □ No

Do you have/own:  Please circle all that apply

□ gym membership  □ treadmill  □ elliptical
□ stationary bike  □ outside bike  □ row machine
□ fitness tracker/watch  □ free weights  ___________

How would you describe your stress level:
At work:  □ minimal  □ moderate  □ high
At home:  □ minimal  □ moderate  □ high

Does it feel manageable?  □ Yes  □ No

How do you like to relax?  ______________________________________
Intake Form

Pick the answer that best describes the way you have been eating over the past two to three months. Feel free to make any comments for clarification.

1. How many times a week did you eat fast food or take out?
   - □ Rare occasion or less
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

2. How many servings (fists) of vegetables did you eat each day?
   - □ 4 or more
   - □ 2-3
   - □ 1 or less
   - □ Not daily

3. How many cups of fruit did you eat each day?
   - □ 4 or more
   - □ 2-3
   - □ 1 or less
   - □ Not daily

4. How many sodas (diet or regular), energy/sports drinks, glasses of juice, or glasses of sweet tea did you drink each day?
   - □ None
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

5. How many times a week did you eat the following: 1 cup of legumes & beans or 3 ounces (palm size) of chicken, fish, bison, or lean pork (chop & tenderloin)?
   - □ Daily
   - □ 4 or more times
   - □ 1-3 times
   - □ Less than 1 time

6. How many times a week did you eat 3 ounces (palm size) of beef, pork, or lamb?
   - □ Less than 1 time
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

7. How many times a week did you eat the following dairy products: 1 ounce (3 dice size or 1 prepackaged slice) of cheese, 1 cup of full fat yogurt or cottage cheese, or 1 cup of whole or 2% milk?
   - □ Less than 1 time
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

8. How many times a week did you eat snack foods (e.g., chips, microwave popcorn, crackers, bars)?
   - □ Rare occasion or less
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

9. How many times a week did you eat baked goods, pastries, or desserts (candy, ice cream)?
   - □ Rare occasion or less
   - □ 1-3 times
   - □ 4 or more times
   - □ Daily

10. Which of the following do you use on a weekly basis?
    - □ Butter
    - □ Margarine
    - □ Coconut oil
    - □ Meat fat
    - □ Canola oil
    - □ Olive oil
    - □ Avocado oil
    - □ Other: _________

Adapted from: Starting the Conversation: Diet (A scale developed by: The Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill, and North Carolina Prevention Partners)
Fatigue Scale

The Fatigue Scale is a method of evaluating the impact of fatigue on you. This is a short questionnaire that requests you to grade your level of fatigue over the past week.

During the past week, I have found that:

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My motivation is lower when I am fatigued.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>2</td>
<td>Exercise brings on my fatigue.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>3</td>
<td>I am easily fatigued.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>4</td>
<td>Fatigue interferes with my physical functioning.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>5</td>
<td>Fatigue causes frequent problems for me.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>6</td>
<td>My fatigue prevents sustained physical functioning.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>7</td>
<td>Fatigue interferes with carrying out certain duties and responsibilities.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>8</td>
<td>Fatigue is among my 3 most disabling symptoms.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>9</td>
<td>Fatigue interferes with my work, family, or social life.</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

**Total Score: ____**

**Scoring your results:**

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It’s simple: Add the numbers you circled to get your total score.

**Key:**
Score of >36 suggests that you may need further evaluation.
Score of <36 suggests that you may not be suffering from fatigue.
Patient Health Questionnaire (PHQ-9)

This questionnaire is an important part of providing you with the best healthcare possible.

Name: ____________________________  Today’s Date: ____________________

MRN # (to be filled in by staff): ________________

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you answered a “2” or “3” to either of the above questions, please answer the remaining 7 questions.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Staff: Please subtotal each column.
Then add columns 1, 2, & 3 for  Total Score = _______