SPENCER KROLL MD PhD FNLA
(732)591-8840 FAX (732) 591-2822

To optimize the visit, Dr. Kroll recommends the following fasting laboratory studies prior to the patient's appointment:
- **Lipid panel (total cholesterol, LDL, HDL, triglycerides)**
- **If you have a high triglyceride level (TG > 200 mg/dL) or a**

low HDL level (HDL < 35 mg/dL), Dr. Kroll requests the following to test for insulin resistance:
- **A fasting insulin**
- **A fasting glucose**
- **Thyroid function tests (Free or total T4 and TSH)**
- **Urinalysis**

Please complete this questionnaire and the 3-Day Diet Recall, and bring them with you to your appointment.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**
Referring doctor address and telephone number:	

PERSONAL HEALTH HISTORY

Do you have a history of?	**Please provide details and dates of diagnosis**
Coronary Artery Disease	
Myocardial Infarction (heart attack)	
Stroke	
Aortic Aneurysm	
Carotid Artery Disease	
Peripheral Vascular Disease	
Chronic Kidney Disease	
Diabetes	
List any other medical problems that have been diagnosed	

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Please list your current medications, including supplements and vitamins. Continue the list on the back if needed. You may also bring your medications into your first appointment.		
Medication	Dose	Date Started
Please list any past medications that you have taken for your cholesterol/lipids		
Medication	Dose	Why was it stopped?

Have you ever had a stress test?	☐ Yes	☐ No
Have you ever had a nuclear stress test?		
Have you ever had a carotid ultrasound?		
Have you ever had a cardiac CT or calcium score		
When was your last eye exam?		
When was your last blood work?		
Have you had any genetic testing for your lipids?		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers PLEASE BRING ALL CURRENT MEDICINE BOTTLES TO YOUR FIRST APPOINTMENT		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

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HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
	Rank Carb intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Genetic Lipid Findings	Do you have any history of tendon problems/tendon ruptures/tendon growths?			☐ Yes	☐ No
	Are you prone to recurrent rashes or skin eruptions?			☐ Yes	☐ No
	Do you have fatty growths anywhere on your body?			☐ Yes	☐ No
	Most Recent TOTAL CHOLESTEROL ______ LDL ______ HDL ______ Triglycerides ______ LDL-P (if known) ________ If you have had additional lipid testing, please describe on the back or attach a copy of those results.			DATE	
Please Check which condition you or your physician might be concerned about:	☐ Resistant or intolerant to prior therapy				
	☐ Suspect genetic dyslipidemia (i.e., TG>500, LDL>190, low HDL, elevated Lp(a))				
	☐ Time to goal is paramount ☐ Metabolic syndrome				
	☐ Complex therapy				
	☐ Drug interaction concern, adverse drug reaction, polypharmacy				
	☐ Adherence concerns				
	☐ Patient is hesitant to begin therapy				
	☐Renal insufficiency				
	☐ Other:				

CHOLESTEROL TREATMENT CENTER

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FAMILY HEALTH HISTORY

PLEASE SPECIFY FAMILY MEMBERS WITH HEART DISEASE, STROKE, DIABETES, KIDNEY DISEASE, HIGH CHOLESTEROL, PERIPHERAL VASCULAR DISEASE

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Please also note other family members (uncles, aunts, cousins) with above diseases

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please describe:

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Before visiting the Cholesterol Treatment Center, please record everything you eat and drink for three days. Choose two weekdays and one weekend day (the days do have be to consecutive).

- Please be as specific as possible and include all beverages, condiments and portion sizes.
- Also include how your food was prepared (for example, indicate if the food was baked, fried, steamed, grilled, microwaved, etc).

Day 1	
Day 2	
Day 3	

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Medical Information Release Form
(HIPAA Release Form)

Name: ___________________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____
[ ] Child(ren)______________________________________
[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: ______________________________________ Date: ____/____/_____