

Patient identification code \_\_\_\_\_ Date of completion (dd/mm/yy) \_\_\_\_\_

Completed by \_\_\_\_\_

**1. Have any of the following diseases/procedures ever been diagnosed/performed\*:**

- a) Myocardial infarction  Yes  No  Unknown If yes, date of diagnosis (mm/yy): \_\_\_\_\_
- b) Stroke  Yes  No  Unknown If yes, date of diagnosis (mm/yy): \_\_\_\_\_
- c) Diabetes mellitus  Yes  No  Unknown If yes, date of diagnosis (mm/yy): \_\_\_\_\_
- d) Coronary artery by-pass grafting  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_
- e) Coronary angioplasty/stenting  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_
- f) Carotid endarterectomy  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_
- g) Non-AIDS defining cancer  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_
- h) Chronic liver disease  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_
- i) End-stage renal disease  Yes  No  Unknown If yes, date of procedure (mm/yy): \_\_\_\_\_

\* All diseases need to meet the criteria for the DAD events listed in the DAD MOOP and the New DAD Endpoint Guidelines

**2. Have any first degree relatives (genetic mother, father, brother, sister) experienced myocardial infarction or stroke before the age of 50 years:**  Yes  No  Unknown

**3. Most recently measured:**

	Not done	Fasting	Value	Unit	Date of measurement (mm/yy)
Serum total cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Serum HDL cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Serum triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

**4. Systolic and diastolic blood pressure**  Not done  Value \_\_\_\_\_/\_\_\_\_\_  Date of measurement (mm/yy) \_\_\_\_\_

**5. Ongoing treatment**

- |                                    |  |   |  |
|------------------------------------|--|---|--|
|                                    | On treatment   |   | On treatment   |
| a) Anti platelets                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | e) Oral antidiabetic agents               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) ACE inhibitors                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | f) Insulin or derivatives hereof          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Antihypertensive agents, others | <input type="checkbox"/> Yes <input type="checkbox"/> No | g) Anabolic steroids/ appetite stimulants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) Lipid lowering agents           | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

**6. Is the patient currently a cigarette smoker**  Yes  No  Unknown

If NO - has he/she ever smoked cigarettes  Yes  No  Unknown

**7. Is the patient experiencing loss of fat from extremities, buttocks or face?**  Yes  No

**8. Is the patient experiencing accumulation of fat in abdomen, neck, breasts or other defined location?**  Yes  No