HEART AND STROKE PREVENTION SELF-ASSESSMENT

The following factors may increase your risk. Check all boxes that apply to you.

Your **AGE** and **SEX** may increase your risk if...
- You are a man over 45 years old.
- You are a woman over 50 years old, **OR** you have passed menopause, **OR** you have had your ovaries removed.

Your **FAMILY HISTORY** may increase your risk if...
- Your father or brother had a heart attack before age 55 **OR** your mother or sister had one before age 65.
- You have a close blood relative who had a stroke.

Your **BLOOD PRESSURE** may increase your risk if...
- Your blood pressure is 140/90 mm Hg or higher, **OR** you’ve been told that your blood pressure is too high.
- You don’t know what your blood pressure is.

**Tobacco SMOKE** increases your risk if...
- You smoke, or live or work with people who smoke every day.

Your total **CHOLESTEROL** and **HDL cholesterol levels** may increase your risk if...
- Your total cholesterol level is 240 mg/dL or higher.
- Your HDL (“good”) cholesterol level is less than 40 mg/dL.
- You don’t know your total cholesterol or HDL levels.

**PHYSICAL INACTIVITY** may increase your risk if...
- You get less than a total of 30 minutes of physical activity on most days.

**Excess BODY WEIGHT** may increase your risk if...
- You are 20 pounds or more overweight for your height and build.

**DIABETES** increases your risk if...
- You have diabetes (a fasting blood sugar of 126 mg/dL or higher), **OR** you need medicine to control your blood sugar.

**Your MEDICAL HISTORY** may increase your risk if...
- You have coronary heart disease, atrial fibrillation or other heart condition(s), **OR** you’ve had a heart attack.
- You’ve been told that you have carotid artery disease, **OR** you’ve had a stroke or TIA (transient ischemic attack), **OR** you have a disease of the leg arteries, a high red blood cell count or sickle cell anemia.
## REQUEST FOR ACCESS TO OR COPIES OF PROTECTED HEALTH INFORMATION

<table>
<thead>
<tr>
<th>Individual's Name</th>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
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<tbody>
<tr>
<td>Home Address</td>
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<td>Home Phone</td>
<td>DATE OF BIRTH</td>
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1. I request that Oregon Imaging Centers provide me with [please check all boxes that apply]:
   - [ ] access to  [ ] my own copy of the requested information checked below:
     - [ ] for the dates from ( _ _/ _ _/_ _) to ( _ _/ _ _/_ _)
     - [ ] and for services provided at the following Oregon Imaging Centers facility or clinic _____________

2. This request is for:
   - [ ] Transcribed reports, including clinical and ancillary reports
   - [ ] Clinical chart notes, may include nursing records, graphic charts and progress notes.
   - [ ] Billing statements (Fax to Tracy Holt at PerSe (559) 455-4004)
   - [ ] Other (specify): __________________________________________

3. I understand that Oregon Imaging Centers or a copy service retained by Oregon Imaging Centers may charge me according to the current Fee Schedule to complete my request, as well as any applicable mailing fees.

__________________________  ________________________
Signature of Patient        Date

__________________________  ________________________
Signature of Personal Representative  Relationship to Patient

Identification

Please route this completed form to OIC’s Health Records Department.

** You will receive a paper copy of your report in the mail **