

Are You at Risk of Cardiovascular Disease?

Everyone can benefit from taking measures to prevent cardiovascular disease. It is often regarded as the silent killer because people do not realise they are at risk until it is too late. To identify if you are at high risk, a simple questionnaire is the first step. If you answer “yes” to many of the following questions then cardiovascular health is definitely a concern:

CARDIOVASCULAR HEALTH QUESTIONNAIRE

YES NO

- | | | |
|--|--------------------------|--------------------------|
| 1. Is your blood pressure above 140/90? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is your pulse after 15 minutes rest above 75? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you more than 14 lbs over your ideal weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you smoke more than 5 cigarettes a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you do less than two hours exercise a week? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you eat more than one spoon of sugar a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you eat meat more than 5 times a week? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is your diet high in saturated or partially hydrogenated fats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you usually add salt to your food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have more than 2 alcoholic drinks a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is there a history of heart disease in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a personal history of heart attack, coronary artery disease, peripheral arterial disease, or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you suffer from kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you often experience periods of stress? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you a post-menopausal woman? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you / have you used oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

Reference website: <http://www.nutri-online1.co.uk/Home/tabid/52/Default.aspx>