GENERAL WELLBEING
Talk about your general mood and feelings over the past few weeks. Mention if you have lost interest or pleasure in most of your usual activities or if you are experiencing feelings of isolation from family and friends.

CONTRACEPTION
Oral contraceptives are usually safe for healthy young women. However, smoking while taking the oral contraceptive pill can increase the risk of heart disease, stroke and blood clots.

Talk about how to quit smoking if taking oral contraceptives.

PREGNANCY HISTORY
Tell your health care professional if you experienced high blood pressure, pre-eclampsia or gestational diabetes during any of your pregnancies and ask to make a plan to monitor your heart disease risk factors.

REFERRALS
Sometimes, you might be referred to see someone else, such as a dietician, physical activity professional, psychologist or cardiologist.

MEDICINES (IF APPROPRIATE)
What is the name of this medicine?

Why do I need to take this medicine(s)?

How long do I need to take my medicines for?

How often do I take my medicines?

Are there any side effects or interactions I need to be aware of?

What do I do if I accidentally miss a dose?

When will I get my medicines reviewed?

FOR MORE INFORMATION:
Heart Foundation Helpline  13 11 12
heartfoundation.org.au/your-heart/women-and-heart-disease

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FAMILY HISTORY, PREGNANCY HISTORY AND AGE
Does my family history put me at greater risk?  ☐ Yes  ☐ No
Does my pregnancy history put me at greater risk?  ☐ Yes  ☐ No
Does my age put me at greater risk?  ☐ Yes  ☐ No

BLOOD PRESSURE
What is my blood pressure?  Current: ____ / ____
What should my blood pressure be?  Ideal: ____ / ____
How often should I have my blood pressure checked?  ____________________________
How can I lower my blood pressure?  ____________________________

CHOLESTEROL
Am I due for a cholesterol test?  ☐ Yes  ☐ No
What is my cholesterol?  TC / LDL / HDL: ____ / ____ / ____
What do my cholesterol numbers mean?  ____________________________
What should my cholesterol goal be?  TC / LDL / HDL: ____ / ____ / ____
What can I do to reduce my cholesterol?  ____________________________

LIFESTYLE
What lifestyle changes can I make to help manage my blood pressure or cholesterol levels?  ____________________________
What types of physical activity can I do?  ____________________________

TESTS (IF APPLICABLE)
What is the name of this test?  ____________________________
Why do I need this test?  ____________________________
How is it done?  ____________________________
Will it hurt?  ____________________________
What are the benefits and risks?  ____________________________
When will I get the results?  ____________________________
Will I need to stay in hospital?  ☐ Yes  ☐ No

Visit details
__________________________________________
__________________________________________
Health care provider’s name
__________________________________________
Date & Time ____________________________

How much physical activity should I be doing?  ____________________________
What is my ideal healthy weight? ____ kg
What can I do to stop smoking (if applicable)?  ____________________________

CHOLESTEROL
Am I due for a cholesterol test?  ☐ Yes  ☐ No
What is my cholesterol?  TC / LDL / HDL: ____ / ____ / ____
What do my cholesterol numbers mean?  ____________________________
What should my cholesterol goal be?  TC / LDL / HDL: ____ / ____ / ____
What can I do to reduce my cholesterol?  ____________________________

LIFESTYLE
What lifestyle changes can I make to help manage my blood pressure or cholesterol levels?  ____________________________
What types of physical activity can I do?  ____________________________

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When will I get the results?  ____________________________
Will I need to stay in hospital?  ☐ Yes  ☐ No