**HEALTH CHECK-UP FORM**

**DATE**

1. **GENERAL INFORMATION**

Name (Initials):\_\_\_\_\_\_ Age (Years).

Gender \* M/F • Email ID:

Marital Status\* Single/ Married

Locality Duration of stay (AQI)

1. **BASIC PARAMETERS**

Blood pressure

Pulse

Weight in kilograms

Current height in meters

BMI (kg/sq meter)

1. **PERSONAL HISTORY**
2. Do you engage in regular **physical activity or exercise**? Y/N

How often??

Daily

3-5 times per week

1-2 times per week

1. What is your typical **diet**? Veg/Non-Veg/Mixed
2. Do you have any preference for junk food like McDonald's Burger? How often do you ask for outside food like Zomato/ Swiggy?

Never

Rarely (Once a month or less)

Occasionally (2-3 times a month)

Regularly (Once a week)

Frequently (Multiple times a week)

1. **EDUCATIONAL LEVEL**

High school/ Undergraduate/ Graduate/ speciality/ Other

1. **PROFESSIONAL LEVEL**

Engineer/ Chemist/ Software Consultant/ Doctor/ Nursing/ Teacher/ Other ➢

6. Do you consume alcohol? Y/N

7. Do you Smoke? Y/N

D.**MEDICAL HISTORY**

High Blood pressure Y/N

Diabetes Y/N

High Cholesterol Y/N

Irregular heartbeats. Y/N

Snoring. Y/N

Other:

If 'other', please specify

How often do you check your Blood Pressure (BP) and blood sugar in case you have one?

Daily

Weekly

Monthly

Every few months

Yearly

Not applicable

**For females:** Have you ever taken oral contraceptives or hormonal therapy? Y/N

Do you currently take any medications (Hormone therapy)? Y/N

History of hypertension during pregnancy Y/N/NA

If 'Yes', please specify:

E.**FAMILY HISTORY**

Do you have a **family history** of brain or heart stroke, hypertension or diabetes? Y/N

How many family members **depend** on you financially or otherwise?

Do you currently have medical insurance? . Y/N

**F.PAST HISTORY**

Thyroid disease

CAD/IHD

Bronchial asthma or OSA

Migraine

**G. SYMPTOMS**

Have you experienced any of the following **symptoms?**

1. Loss of balance or coordination.

2. Sudden vision changes, such as blurred vision or loss of vision in one or both eyes.

3. Tingling, numbness in the limbs

4. Sudden weakness or heaviness of the limbs or facial weakness.

5. Difficulty speaking, slurred speech, or trouble understanding speech. 6. Severe headache with no known cause.

7. Repeated episodes of giddiness/early morning dizziness

8. Frequent episodes of severe fatigue

None of the above

The following regression parameters were used to assign risk points.

| **NO** | **RISK FACTORS** | **SCORE** | **Value** |
| --- | --- | --- | --- |
| **11** | **SMOKING or chronic Tobacco consumption** | 1 |  |
| **2** | **HYPERTENSION (>140/90)** | 4 |  |
| **3** | **AGE more than 60** | 1 |  |
| **4** | **ALCOHOL ABUSE** | 1 |  |
| **5** | **ATRIAL FIBRILLATION-irregular pulse** | 4 |  |
| **6** | **DIABETES-RBS>200, HbA1C>6.5** | 2 |  |
| **7** | **OBESITY (BMI >30)** | 1 |  |
| **8** | **WELLSPRING**  **(Family History)** | 1 |  |
| **9** | **STRESS (PSS level 3,4)** | 1 |  |
| **10** | **SEDENTARY LIFE STYLE**  **(Lack of exercise)** | 1 |  |
| **11** | **HISTORY OF TIA** | 1 |  |
| **12** | **HISTORY of previous brain stroke, Coronary or Kidney disease** | 1 |  |
|  | **TOTAL** |  |  |

Hypertension: BP >140/90.

BMI (body mass index) kg/sq meter

Wellspring: family history

TIA: Transient Ischemic attacks

CAD: coronary heart disease or stroke

**ASSESSMENT OF** **RISK SCORE**

a. Low score 3 or <3

b. Moderate score. 4-7

c. High score > 7

**RECOMMENDATIONS**

a.Low score: Healthy indivisual

b. Moderate- dietary advice, exercises, control and monitoring of risk factor,

C. High score

In addition to dietary advice, exercises

a. Ophthalmic reference- Retina study

b. Cardiology reference

C. Neurology reference

**Recommended Basic investigations for High score candidates**

ECG, 2D Echo, Treademill

Fundoscopy, retinal picture

Renal workup

Biochemical markers

CBC, CRP

Serum Homocysteine

Lipid Profile

Lipoprotein A

Bun, Serum creatinine

Radiological Investigations- Carotid doppler with flow velocities

CT brain with CTA or

MRI brain with MRA

Other investigations as per the organ involvement

**Creating Red flags:**

Create a separate data sheet.

Regular follow-up for fresh complaints, examination,

Repeat markers as the situation demands.

This can be done by a General physician trained in neurology.

Prevention is the most effective way to reduce the effects of stroke on individuals and their families. Communicating risk to the general population requires simple tools relevant to the typical individual, who is likely to have more than one risk factor or engage in risky behaviour. The American Heart Association's guidelines regarding primary stroke prevention concur with this and state that risk assessment is vital for the general public.

**References**

1. Goldstein LB, Adams R, Alberts MJ, Appel LJ, Brass LM, Bushnell CD, et al. Primary prevention of ischemic stroke: a guideline from the American Heart Association/American Stroke Association Stroke Council. *Stroke.* 2006;37:1583– 1633.)

**2.** MyRisk\_Stroke Calculator: A Personalized Stroke Risk Assessment Tool for the General Population Lisa Nobel,a,b Nancy E. Mayo,a,b James Hanley,a,b Lyne Nadeau,b Stella S. Daskalopoulouc, J Clin Neurol 2014;10:1-9.