British Women's Heart and Health Study

Name:

Address:

Date of birth:

NHS Number:

Postcode:

Practice ID:

Health Record Review 2016

Please tick which applies, (Yes or No) to the questions below:

	Yes[1]	No[2]
Are the above details correct and complete? *(Please correct if necessary)*		
Is the above named patient still registered with your practice?		

PLEASE RECORD ANY OF THE FOLLOWING EVENTS IN THE PERIOD FROM **1ST OCTOBER 2011** TO DATE

Please tick which applies, (Yes or No) to the events below and give the date(s) when they occurred:

Event	Yes[1]	No[2]	Date(s) of the event Day/Month/Year	Day/Month/Year	Day/Month/Year
* Myocardial Infarction (MI), Heart attack [1]			/ /	/ /	/ /
* Unstable Angina [13]			/ /	/ /	/ /
* Angina [2]			/ /	/ /	/ /
* Heart Failure [12]			/ /	/ /	/ /
* Stroke, cerebrovascular accident (CVA) [3]			/ /	/ /	/ /
* Transient ischaemic attack, mini stroke (TIA) [4]			/ /	/ /	/ /
Angioplasty, balloon catheter treatment (PTCA) [5]			/ /	/ /	/ /
Carotid endarterectomy [6]			/ /	/ /	/ /
Coronary artery by-pass graft (CABG) [7]			/ /	/ /	/ /
* Diabetes (NIDDM/IDDM)[8]			/ /	/ /	/ /
* Any Cancer – please give site of cancer [9]			/ /	/ /	/ /
Deceased [10]			/ /		
Has a Cardiovascular Disease Risk Score[11] been calculated? By which method and what is the score?			Risk-score method	Latest Score or %risk	Date / /

**** Please include a copy of the initial hospital letter concerning the diagnosis for any events that occurred under these headings and for which there is a hospital letter.***

Please turn over…

Study ID:

PLEASE RECORD ANY OF THE FOLLOWING EVENTS IN THE PERIOD FROM
1ST OCTOBER 2011 TO DATE

Event	Yes[1]	No[2]	Date(s) of the event Day/Month/Year	Day/Month/Year	Day/Month/Year
* Pulmonary Embolism (PE)[14]			/ /	/ /	/ /
* Deep Vein Thrombosis (DVT)[15]			/ /	/ /	/ /

PLEASE RECORD ANY OF THE FOLLOWING EVENTS IN THE PERIOD FROM
1ST JANUARY 2000 TO DATE

Event	Yes	No	Date	Date	Date
* Atrial Fibrillation (AF)			/ /	/ /	/ /
* Dementia (types?)			/ /	/ /	/ /

**** Please include a copy of the initial hospital letter concerning the diagnosis for any events that occurred under these headings and for which there is a hospital letter.***

Please sign and date:

Reviewers Name: ……………………………………………………..Date: ...…../…..…/………..

PLEASE RETURN THIS FORM TO:

Julie Taylor
Research Coordinator
British Women's Heart and Health Study
UCL Farr Institute
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London
NW1 2DA