

PHYSICAL EXAM				
DOB _____	Age _____	<input type="checkbox"/> Female <input type="checkbox"/> Male	Weight _____	Height _____
BP _____ <input type="checkbox"/> Normal range (90–119/60–79) <input type="checkbox"/> Prehypertension (120–139/80–89) <input type="checkbox"/> Stage 1 hypertension (140–159/90–99) <input type="checkbox"/> Stage 2 hypertension ($\geq 160/\geq 100$)		BMI _____ $[\text{weight (lbs)}/\text{height (in)}^2] \times 703$ <input type="checkbox"/> Normal range (19–24.9) <input type="checkbox"/> Overweight (25–29.9) <input type="checkbox"/> Obese (>30)		
PSORIASIS				
# Years with disease _____		Treatment _____		
<input type="checkbox"/> Well controlled <input type="checkbox"/> Not well controlled				
LABORATORY				
Lipid panel Date last _____				
Total cholesterol _____ <input type="checkbox"/> Normal (<200 mg/dL) <input type="checkbox"/> Borderline–high (200–239 mg/dL) <input type="checkbox"/> High (≥ 240 mg/dL)		LDL _____ <input type="checkbox"/> Optimal (<100 mg/dL) <input type="checkbox"/> Near–above optimal (100–129 mg/dL) <input type="checkbox"/> Borderline high (130–159 mg/dL) <input type="checkbox"/> High (160–189 mg/dL) <input type="checkbox"/> Very high (≥ 190 mg/dL)		
TG _____ <input type="checkbox"/> Normal (<150 mg/dL) <input type="checkbox"/> Borderline high (150–199 mg/dL) <input type="checkbox"/> High (200–499 mg/dL) <input type="checkbox"/> Very high (≥ 500 mg/dL)		HDL _____ <i>Male</i> <input type="checkbox"/> Normal (40–50 mg/dL) <input type="checkbox"/> Low (<40 mg/dL) <i>Female</i> <input type="checkbox"/> Normal (50–60 mg/dL) <input type="checkbox"/> Low (<50 mg/dL)		
Fasting glucose / Hb A1C (circle one) _____ Date last _____ <input type="checkbox"/> Normal (<100 mg/dL) <input type="checkbox"/> Pre-diabetes (100–125 mg/dL) <input type="checkbox"/> Diabetes (>125 mg/dL)		hsCRP Date last _____ <input type="checkbox"/> Low risk (<1.0 mg/L) <input type="checkbox"/> Average risk (1–3 mg/L) <input type="checkbox"/> High risk (>3.0 mg/L)		
LIFESTYLE				
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of years _____	# packs/day _____	
Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Strenuous
Alcohol intake	<input type="checkbox"/> Yes <input type="checkbox"/> No	# drinks/week _____		
EDUCATION				
<input type="checkbox"/> Exercise		<input type="checkbox"/> Smoking cessation		
<input type="checkbox"/> Weight loss		<input type="checkbox"/> Decrease saturated fat intake		
<input type="checkbox"/> Moderate alcohol intake				
REFERRAL				
<input type="checkbox"/> Primary Care		<input type="checkbox"/> Endocrinologist		
<input type="checkbox"/> Cardiologist		<input type="checkbox"/> Other _____		