American Heart Association.

Top Questions to Ask Your Health Care Professional

Use this guide to understand your results, discuss your risk and plan next steps with your health care team.

My Test Results

Lipid Panel

Total Cholesterol: _____

LDL (Bad Cholesterol): _____

HDL (Good Cholesterol): _____

Triglycerides: _____

Other Tests (as applicable)

Lp(a): _____ ApoB: _____

Coronary Artery Calcium (CAC) Score: _____

Know My Cholesterol

Most people have no symptoms, so a simple blood test is the only way to know your cholesterol levels.

- What do my levels mean?
- Which number is the most important for my heart health?
- Can high cholesterol cause health problems even if I feel fine?

Understand My Risk

Cholesterol can build up in the arteries and reduce blood flow, raising the risk of heart attack and stroke. Risk is also affected by family history, age, reproductive health history, other health conditions, and lifestyle habits.

- How do my cholesterol levels affect my risk for heart attack or stroke?
- Based on my personal health factors, does this increase my risk for heart attack and stroke?
- What other screenings may give a clearer picture of my risk of heart attack and stroke?

My Treatment Plan

Lowering cholesterol starts with healthy lifestyle habits, and some people may need medication. Supplements aren't recommended and may interact with medication, so talk with a health care professional if you take them.

- **Eating Pattern:** Am I following a heart-healthy eating pattern? ◯Yes ◯No
  - ◊ Eat more of:
  - ◊ Eat less of:
- **Physical Activity:** Do I get regular physical activity (such as 30 minutes of moderate physical activity per day)? ◯Yes ◯No
  - ◊ Goal & days per week:
- **Weight:** Am I at a healthy weight? ◯Yes ◯No
  - ◊ Goal & timeline:

- **Other Health Factors:**
  - ◊ Blood Pressure _____
  - ◊ Diabetes (A1C) _____
  - ◊ Other _____
- **Tobacco/Nicotine Use** (including e-cigarettes and vaping)? ◯Yes ◯No
  - ◊ If yes, I plan to quit by _____
- **Sleep:** Am I getting 7–9 hours of restful sleep most nights? ◯Yes ◯No
- **Medication:** Do I need cholesterol-lowering medication? ◯Yes ◯No
  - ◊ If yes, which medication is recommended? _____
  - ◊ Dosage: _____
  - ◊ Frequency: _____
- **Next appointment:** _____
- **Notes:** _____

Find helpful tools and resources at heart.org/Cholesterol.