



Patient Questionnaire

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: () _____

Daytime Phone: () _____ Mobile Phone: () _____

Social Sec. #: _____ Married Single Widow

Spouse's First Name: _____ Middle Initial: _____ Last Name: _____

Spouse's Social Sec. #: _____ Daytime Phone: () _____

Emergency Contact and Relationship: _____

Emergency Phone: () _____ Referring Physician: _____

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly describe your reason for consulting a heart doctor today:

Current Allergies:

Do you have ALLERGIES TO IODINE, seafood or radiographic contrast dye? YES NO

Please list any other allergies and describe the reaction:

Allergy to:	Reaction:
_____	_____
_____	_____
_____	_____

If more space is needed,
you can use the bottom of
the last page of this form.

Current Medications:

♥Remember to bring all medications with you at time of appointment

Please list all medications (prescription and non-prescription) that you are now taking or occasionally take:

Medication Name	Dosage	How Often Taken?	Who prescribed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

Please check if you had any of the following problems in the past:

Heart Attack?	_____	Congestive Heart Failure?	_____
Blackouts or Fainting spells?	_____	High blood pressure?	_____
Frequent dizzy spells?	_____	Rheumatic Heart Disease?	_____
Blood clots in veins or legs?	_____	Infection in the heart?	_____
Abnormal EKG?	_____	Blood clots in lungs or legs?	_____
Palpitations, skips, or irregular heartbeat?	_____	Abnormal heart rhythms?	_____
Pain in the arms, throat, jaw or upper back?	_____	Chest Pain, pressure, or tightness?	_____

Past Cardiac Procedures or Tests:

	Date	Location	Physician
Heart Catheterization (dye test)	_____	_____	_____
Heart Surgery (bypass, valve replacement)?	_____	_____	_____
Other blood vessel surgery?	_____	_____	_____
Electrophysiology Study?	_____	_____	_____
Pacemaker or AICD Implantation?	_____	_____	_____
Echocardiogram?	_____	_____	_____
Stress Test (Treadmill, etc.)?	_____	_____	_____
Holter Monitor?	_____	_____	_____

Past Medical Illnesses:

Please list any serious illness for which you have been hospitalized (except admissions just for surgery)

Past Surgeries:

Please provide the year for all that apply

Gallbladder _____	Tonsillectomy _____	Appendix _____
Hysterectomy _____	Prostate _____	Hernia _____
Breast biopsy or mastectomy _____	Other operations: _____	

Social History and Lifestyle:

Do you drink alcohol? YES NO If YES, How many drinks on an average day? _____

Do you currently smoke? YES NO If YES, How much do you smoke? _____

How long have you been smoking? _____ If you quit smoking, when did you quit? _____

How many packs a day did you smoke? _____ How many years did you smoke before quitting? _____

Are you on a special diet? YES NO If YES, What type of diet? _____

How many cups of caffeinated beverages do you drink on an average day? _____

Do you exercise on a regular basis? YES NO If YES, What type of exercising and how often? _____

Do you have a history of drug dependency? YES NO If YES, Specify: _____

Place of Birth: _____ Religion: _____

Education (highest level): _____ Occupation: _____ Hours Worked per Week: _____

Marital Status: Single Married Divorced Widowed Spouse Occupation: _____

Do you live: Alone With Spouse Children Other

Family History: Please list any brothers, sisters, parents, or children who have had heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells.

Relationship: _____ Condition: _____ at what age: _____ Deceased: Y N

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Review of Systems:

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:

- Decreased exercise tolerance? YES NO _____
- Fatigue? YES NO _____
- Weight change? Gain Loss YES NO _____
- Change in Appetite? YES NO _____

Integumentary (Skin):

- Changes in moles? YES NO _____
- Rash? YES NO _____
- Itching? YES NO _____
- Changes in hair? YES NO _____
- Changes in nails? YES NO _____

Eyes:

- Do you wear glasses/contact lenses? YES NO _____
- Do you have blurred vision? YES NO _____
- Do you experience double vision? YES NO _____
- Do you have a history of cataracts? YES NO _____
- Glaucoma? YES NO _____

Ear, Nose, Mouth and Throat:

- Do you have a hearing deficit? YES NO _____
- Do you wear dentures/braces? YES NO _____
- Chronic sinus problems? YES NO _____
- Do you have nose bleeds? YES NO _____
- Hoarseness/Changes in voice? YES NO _____

Respiratory:

- Do you wheeze? YES NO _____
- Do you have a chronic cough? YES NO _____
- Have you coughed up blood? YES NO _____
- Do you experience shortness of breath?
 At rest? With activity? YES NO _____
- Do you snore? YES NO _____

Cardiovascular:

- Chest pain, pressure or tightness?
 At rest? With activity? YES NO _____
- Heart palpitations (racing)? YES NO _____
- Irregular heart beats? YES NO _____
- Short of breath lying flat? YES NO _____
- Waking up panicky, short of breath? YES NO _____
- Have you passed out? YES NO _____
- Swelling of feet or ankles? YES NO _____
- Pain in legs with walking? YES NO _____

Gastrointestinal System:

- Frequent nausea? YES NO _____
- Frequent vomiting? YES NO _____
- Abdominal pain? YES NO _____
- Black, tarry stool? YES NO _____
- Bright red blood in stool? YES NO _____
- History of stomach ulcers? YES NO _____
- Frequent diarrhea? YES NO _____
- History of gallbladder problems? YES NO _____
- History of liver problems? YES NO _____

Genitourinary:

- Do you have pain with urination? YES NO _____
- Sense of urgency to urinate? YES NO _____
- Awaken frequently to urinate? YES NO _____
- History of bladder, kidney infection? YES NO _____
- History of kidney stone? YES NO _____
- Males: Prostate problems? YES NO _____
- Females: Post menopausal? YES NO _____
- Currently taking hormone replacement? YES NO _____

Musculoskeletal:

- Chronic back pain? YES NO _____
- Arthritis? YES NO _____
- History of gout? YES NO _____
- Joint pain or stiffness YES NO _____
- Muscle pain or cramps? YES NO _____
- Muscle weakness? YES NO _____
- History of blood clots in legs? YES NO _____
- History of varicose veins? YES NO _____

Neurological:

- Temporary blurred vision/loss of vision? YES NO _____
- Temporary weakness and/or tingling involving an arm or leg? YES NO _____
- Severe headaches? YES NO _____
- Migraine headaches? YES NO _____
- Convulsions/Seizures? YES NO _____

Psychiatric:

- History of depression? YES NO _____
- Chronic Anxiety? YES NO _____
- Stress at work or home? YES NO _____
- History of drug or alcohol abuse? YES NO _____
- Trouble sleeping? YES NO _____
- Thoughts of suicide? YES NO _____

Endocrine:

- Fatigue? YES NO _____
- High cholesterol? YES NO _____
- Diabetes? YES NO _____
- Thyroid problems? YES NO _____

Hematological/Immunologic:

Chronic low blood count/anemia?

YES NO

Bleeding problems?

YES NO

Seasonal allergies?

YES NO

Food allergies?

YES NO

Thank you. Again, please be sure to bring all your medicines to each visit with us.