



### Patient Questionnaire

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Ethnicity \_\_\_\_\_ Race: \_\_\_\_\_ Language(s) spoken: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Daytime #:( ) \_\_\_\_\_ Cell #:( ) \_\_\_\_\_

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 if 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Bleeding problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Seasonal allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Food allergies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

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