



### 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?                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Frequent vomiting?               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Abdominal pain?                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Black, tarry stool?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Bright red blood in stool?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of stomach ulcers?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Frequent diarrhea?               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of gallbladder problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of liver problems?       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Genitourinary:**

- |                                       |                              |                             |       |
|---------------------------------------|------------------------------|-----------------------------|-------|
| Do you have pain with urination?      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Sense of urgency to urinate?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Awaken frequently to urinate?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of bladder, kidney infection? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of kidney stone?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Males: Prostate problems?             | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Females: Post menopausal?             | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Currently taking hormone replacement? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Musculoskeletal:**

- |                                 |                              |                             |       |
|---------------------------------|------------------------------|-----------------------------|-------|
| Chronic back pain?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Arthritis?                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of gout?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Joint pain or stiffness         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Muscle pain or cramps?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Muscle weakness?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of blood clots in legs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of varicose veins?      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Neurological:**

- |  |                              |                             |       |
|--|------------------------------|-----------------------------|-------|
| Temporary blurred vision/loss of vision?                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Temporary weakness and/or tingling<br>involving an arm or leg? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Severe headaches?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Migraine headaches?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Convulsions/Seizures?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Psychiatric:**

- |                                   |                              |                             |       |
|-----------------------------------|------------------------------|-----------------------------|-------|
| History of depression?            | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Chronic Anxiety?                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Stress at work or home?           | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| History of drug or alcohol abuse? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Trouble sleeping?                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Thoughts of suicide?              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

**Endocrine:**

- |                   |                              |                             |       |
|-------------------|------------------------------|-----------------------------|-------|
| Fatigue?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| High cholesterol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Diabetes?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Thyroid problems? | <input type="checkbox"/> YES | <input type="checkbox"/> 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.