New Patient Medical Questionnaire

DATE: _______/_______/_______

Patient Name:_________________________DOB:_____________AGE: _____________

Primary Care Physician:_____________________________City/State: ____________________

Other Physicians: ____

Pharmacy:___________________________City/Intersection/Phone:_________________________

What physician requested this consultation? ____

CHIEF COMPLAINT

What problems are you here for today? ____

____

CARDIAC PROBLEM LIST

Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.

CARDIAC:

☐ **Yes** ☐ **No** Cardiomegaly (Enlarged Heart) _________

☐ **Yes** ☐ **No** Heart Disease you were born with(congenital)____

☐ **Yes** ☐ **No** Rheumatic Fever ______________________

☐ **Yes** ☐ **No** Murmur_____________________________

☐ **Yes** ☐ **No** Abnormal Heart Valve __________________

☐ **Yes** ☐ **No** Endocarditis (infected heart valve)___________

☐ **Yes** ☐ **No** Abnormal ECG________________________

☐ **Yes** ☐ **No** Angina (heart pain)____________________

☐ **Yes** ☐ **No** Heart Attack _________________________

☐ **Yes** ☐ **No** Coronary Artery Disease _________________

☐ **Yes** ☐ **No** Heart Failure / Cardiomyopathy _____________

☐ **Yes** ☐ **No** Arrhythmia / Abnormal Rhythm_____________

☐ **Yes** ☐ **No** Previous Cardiac Arrest _________________

☐ **Yes** ☐ **No** Defibrillated / Shocked _________________

☐ **Yes** ☐ **No** Pericardial(sac surrounding heart) Disease_____

☐ **Yes** ☐ **No** Marfan's Syndrome____________________

☐ **Yes** ☐ **No** Hospitalized for cardiac reasons_____________

☐ **Yes** ☐ **No** Other type of heart disease________________

VASCULAR:

☐ **Yes** ☐ **No** Carotid Artery Disease __________________

☐ **Yes** ☐ **No** Renal(kidney) Artery Disease _____________

☐ **Yes** ☐ **No** Peripheral(leg or arm) Artery Disease _________

☐ **Yes** ☐ **No** Pulmonary embolism (clots in lung) __________

☐ **Yes** ☐ **No** Varicose Veins ________________________

☐ **Yes** ☐ **No** Stroke or TIA (mini-stroke)_______________

☐ **Yes** ☐ **No** Any history of aneurysm _________________

☐ **Yes** ☐ **No** DVT (clots in leg) ____________________

☐ **Yes** ☐ **No** Other type of vascular Disease _____________

CORONARY RISK FACTORS

☐ **Yes** ☐ **No** Hypertension (high blood pressure) ___________

☐ **Yes** ☐ **No** Abnormal Cholesterol / Triglycerides___________

☐ **Yes** ☐ **No** History coronary disease in immediate family?

☐ **Yes** ☐ **No** Diabetes Mellitus ______________________

☐ **Yes** ☐ **No** Currently Smoking?______________________

☐ **Yes** ☐ **No** Peripheral artery disease? (legs, carotids)______

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Revision Date 7/20/2017 LSW

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HeartPlace **New Patient Medical Questionnaire**

Patient Name:____________________________________DOB:______________AGE: _______________

CURRENT MEDICATIONS / SUPPLEMENTS ☐ Yes ☐ No

Please list ALL the medications that you are taking at home. Include ALL prescription medications, non-prescription medications, vitamins, herbal remedies and supplements.

	Name of Medication	Dose/Strength	How Many/How Often/When
Example	*Lasix*	*40 mg*	*twice a day - morning and night*
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

(Please attach additional pages if necessary)

ALLERGIES / INTOLERANCES TO MEDICATIONS ☐ Yes ☐ No

Please list any medications, or materials you are allergic to, had an adverse reaction to, or do not tolerate and describe the reaction.

Medication	Reaction (e.g. hives, swelling, short of breath, rash, etc)

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CARDIAC PROCEDURES/DIAGNOSTIC TESTING ☐ Yes ☐ No

Please check that you have had or have not had any procedures / diagnostic tests. Write the year / location of the test in the blanks indicated.

		Procedure	Year	Location
❑ Yes	❑ No	Echo (Heart Ultrasound)	________	________________________________
❑ Yes	❑ No	Stress Test	________	________________________________
❑ Yes	❑ No	Holter/Event Monitor	________	________________________________
❑ Yes	❑ No	Carotid Artery Ultrasound	________	________________________________
❑ Yes	❑ No	Heart Catheterization	________	________________________________
❑ Yes	❑ No	Heart Angioplasty/Stent Placement	________	________________________________
❑ Yes	❑ No	Peripheral Artery Angiogram (Non Heart)	________	________________________________
❑ Yes	❑ No	Peripheral Artery Angioplasty (Non Heart)	________	________________________________
❑ Yes	❑ No	Electrophysiology Study	________	________________________________
❑ Yes	❑ No	Heart Rhythm Ablation	________	________________________________
❑ Yes	❑ No	Pacemaker/ICD(defibrillator)	________	________________________________
❑ Yes	❑ No	Cardiac Surgery	________	________________________________

LAB WORK: Month & Year of most recent?________________________Location? ______________________

PAST MEDICAL HISTORY

Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.

PULMONARY:

☐ **Yes** ☐ **No** Asthma _________________________

☐ **Yes** ☐ **No** Emphysema / COPD _________________

☐ **Yes** ☐ **No** Pneumonia ________________________

☐ **Yes** ☐ **No** Bronchitis ________________________

☐ **Yes** ☐ **No** Tuberculosis ______________________

☐ **Yes** ☐ **No** Sleep Apnea ______________________

GASTROINTESTINAL:

☐ **Yes** ☐ **No** Reflux(GERD)______________________

☐ **Yes** ☐ **No** Diverticulosis / Diverticulitis _____________

☐ **Yes** ☐ **No** Liver Disease / Hepatitis ______________

☐ **Yes** ☐ **No** Gallbladder Disease / Gallstones __________

☐ **Yes** ☐ **No** Hiatal Hernia _____________________

☐ **Yes** ☐ **No** Ulcers __________________________

☐ **Yes** ☐ **No** Gastritis _________________________

☐ **Yes** ☐ **No** Gastrointestinal Bleed ______________

RENAL / GENITOURINARY:

☐ **Yes** ☐ **No** Dialysis _________________________

☐ **Yes** ☐ **No** Kidney Stones _____________________

☐ **Yes** ☐ **No** Prostate Disease ___________________

☐ **Yes** ☐ **No** Kidney Disease / Elevated Creatinine _______

NEUROLOGICAL / PSYCHOLOGICAL:

☐ **Yes** ☐ **No** Intracranial (in the brain) Bleeding _________

☐ **Yes** ☐ **No** Migraine Headaches __________________

☐ **Yes** ☐ **No** Depression ________________________

☐ **Yes** ☐ **No** Seizure Disorder ____________________

☐ **Yes** ☐ **No** Dementia ________________________

☐ **Yes** ☐ **No** Anxiety Disorder ____________________

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Patient Name:____ DOB:________________ AGE: _________________

FEMALE REPRODUCTIVE: ☐ **Not Applicable**

☐ **Yes** ☐ **No** Multiple miscarriages______________________

☐ **Yes** ☐ **No** Currently Pregnant (number of weeks?)________

☐ **Yes** ☐ **No** Menopause (at what age?)__________________

ENDOCRINE:

☐ **Yes** ☐ **No** Thyroid Disorder ______________________

☐ **Yes** ☐ **No** Adrenal Disorder ______________________

OTHER:

☐ **Yes** ☐ **No** Anemia ______________________

☐ **Yes** ☐ **No** Bleeding Disorder ______________________

☐ **Yes** ☐ **No** Clotting Disorder______________________

☐ **Yes** ☐ **No** Gout ______________________

☐ **Yes** ☐ **No** Arthritis ______________________

☐ **Yes** ☐ **No** Ambulate with assistance________________

☐ **Yes** ☐ **No** HIV______________________

☐ **Yes** ☐ **No** Previous weight Loss meds (i.e. Fen Phen) ____

☐ **Yes** ☐ **No** Reaction to iodine contrast________________

☐ **Yes** ☐ **No** Previous exposure to iodine contrast

☐ **Yes** ☐ **No** Vertigo______________________

☐ **Yes** ☐ **No** Cancer (type?) ______________________

☐ **Yes** ☐ **No** Autoimmune Disorders (i.e. Lupus) __________

Please list any other health problems that are not on the list:

____

____

____

SURGICAL HISTORY / OPERATIONS ☐ Yes ☐ No

Please list any surgeries you have had and include the year and location.

Surgery	Date	Surgeon	Location
Example: Gallbladder Removed	*1980*	*Dr. Frank Smith*	*Parkland, Dallas*

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SOCIAL HISTORY

Marital Status?: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Previously Widowed

Number of sons?:_______Number of daughters?:________Current hometown?: ________________________________

With whom do you live? ____

Do you have a Medical Power of Attorney? ☐ Yes ☐ No Who? ____

Advanced Directives?: ☐ None ☐ **D**o **N**ot **R**esuscitate ☐ Healthcare Proxy ☐ Living Will Date: ____________

Are you retired?: ☐ Yes ☐ No Current or Previous Occupation: _______________________________________

Primary language?______________________________ Secondary language?____________________________

Leisure activities?: (Include any hobbies) ____

Home exercise equipment? ☐ Yes ☐ No If yes, what types:_ ____

Home blood pressure monitor? ☐ Yes ☐ No If yes, average readings: ____________________________________

Do you use tobacco? ☐ Yes ☐ Formerly ☐ Never

Type:	**How much:**	**Start/Quit Dates**	
☐ Cigarettes	_____________per day	Years Smoked?________________	Quit Date? ________________
☐ Cigars	_____________per day	Years Smoked?________________	Quit Date? ________________
☐ Pipes	_____________per day	Years Smoked?________________	Quit Date? ________________
☐ Chewing tobacco	_____________per day	Years Used?__________________	Quit Date? ________________

Do you use alcohol? ☐ Yes ☐ Formerly ☐ Never

Describe your use?

☐ Rarely ☐ Social ☐ Daily ☐ Frequently ☐ Occasional ☐ Quit (when)

Type:	**How much:**	
☐ Beer	______ cans	per day / wk / mo / yr
☐ Wine	______glasses	per day / wk / mo / yr
☐ Spirits	______glasses	per day / wk / mo / yr

Do you use caffeine? ☐ Yes ☐ Formerly ☐ Never

Type:

☐ Caffeinated Coffee?________cups per	day / wk / mo / yr	☐ Quit (when) _______
☐ Caffeinated Tea?________cups per	day / wk / mo / yr	☐ Quit (when) _______
☐ Caffeinated Soda?_________cans per	day / wk / mo / yr	☐ Quit (when) _______
☐ Chocolate?________servings per	day / wk / mo / yr	☐ Quit (when) _______

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New Patient Medical Questionnaire

Patient Name:______________________________________DOB:_______________AGE: ________________

Do you use recreational drugs? __________ ☐ Yes ☐ Formerly ☐ Never

Type:	How much:	Start/Quit Dates		
☐ Marijuana	___________________per day/wk/mo/yr	When did your start?_________	Quit?_________	Rehab? _________
☐ Cocaine	___________________per day/wk/mo/yr	When did your start?_________	Quit?_________	Rehab? _________
☐ Methamphetamine	___________________per day/wk/mo/yr	When did your start?_________	Quit?_________	Rehab? _________
☐ Other	___________________per day/wk/mo/yr	When did your start?_________	Quit?_________	Rehab? _________

Exercise?

☐ No/Sedentary ☐ Occasional ☐ Regular ☐ Active Lifestyle ☐ Physically Unable to exercise

Type:	How much:		Check any applicable:
☐ Aerobics	How long? (Mins.)________________	How often? (Per wk) ______________	☐ Started Exercising
☐ Cycling	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Dancing	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Jogging	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Running	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Swimming	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Team sports _________	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Walking	How long? (Mins.)________________	How often? (Per wk) ______________	
☐ Weights	How long? (Mins.)________________	How often? (Per wk) ______________	

Please choose the type of diet you are currently on?

Type:	How well do you follow diet:			
☐ Regular				
☐ Low fat/Chol	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Low salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Diabetic	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Renal	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ No Added Salt	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Weight Loss	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Low Carb	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet
☐ Vegetarian	☐ Strictly	☐ Usually	☐ Occasionally	☐ Non –compliant with diet

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FAMILY HISTORY ☐ **Adopted**

Please indicate below if your FATHER, MOTHER, SIBLING(S), or CHILDREN have ever been diagnosed with any of the following conditions, by writing the **age** (not a check mark!) at which the condition first occurred in the appropriate box. **PLEASE NOTE**: If there is no history of these conditions or if they are unknown, THEN check the **None** or **Unknown** box in the appropriate column.

Condition	Father	Mother	Sister(s)	Brother(s)	Child(ren)
Angina					
Heart Attack					
Angioplasty					
Heart Surgery					
Abnormal Heart Rhythm					
Sudden/Unexpected Death					
Stroke/TIA (mini stroke)					
Blood Clots					
Heart Failure/Cardiomyopathy					
Aneurysm					
None of the above					
Unknown					
Current age					
Deceased age					

Other family members (aunts, uncles, cousins, grandparents) with heart problems:

____

____

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New Patient Medical Questionnaire

Patient Name:_________________________________DOB:_____________AGE: ______________

REVIEW OF SYSTEMS

Please check the "Yes" or "No" box to indicate if you are experiencing or have experienced any of the following signs or symptoms in the last three months.

CONSTITUTIONAL:	**YES**	**NO**
Significant weight loss	☐	☐
Significant weight gain	☐	☐
ENMT:	**YES**	**NO**
Excessive Snoring	☐	☐
RESPIRATORY:	**YES**	**NO**
Coughing up blood	☐	☐
GASTROINTESTINAL:	**YES**	**NO**
Blood in stools (black stools)	☐	☐
GENITOURINARY:	**YES**	**NO**
Blood in urine	☐	☐
VASCULAR:	**YES**	**NO**
Calf pain with walking	☐	☐
MUSCULOSKELETAL:	**YES**	**NO**
Muscle pain at rest	☐	☐
NEUROLOGICAL:	**YES**	**NO**
Dizziness	☐	☐
PSYCHIATRIC:	**YES**	**NO**
Excessive stress	☐	☐
ENDOCRINE:	**YES**	**NO**
Feel cooler than others	☐	☐
HEMATOLOGICAL:	**YES**	**NO**
Unusual bleeding	☐	☐

CARDIAC:	**YES**	**NO**
Chest pain	☐	☐
Chest pressure	☐	☐
	YES	**NO**
Shortness of breath	☐	☐
Difficulty breathing while laying flat	☐	☐
Awakening with breathing difficulty	☐	☐
	YES	**NO**
Swelling in feet/ankles	☐	☐
	YES	**NO**
Palpitations	☐	☐
	YES	**NO**
Nearly passing out spells	☐	☐
Passing out spells	☐	☐

Any other reason why you need to see a cardiologist?

____
____
____
____
____
____
____
____
____

Thank you for taking the time to complete this questionnaire.

Patient Signature ____________________________

Reviewed By:______________________

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