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NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH:_____ DATE OF VISIT:_____
PRIMARY CARE PHYSICIAN: _____
OTHER PHYSICIANS (THAT YOU WISH TO RECEIVE RECORDS):_____

1. **Reason for visit**:
   - ☐ Main complaint or concern (specify): _____
   - ☐ Establish Cardiovascular Care / Risk Assessment

2. **Care Team – please identify**
   a. Primary Care Provider_____
   b. Other physicians that need to receive your cardiovascular care records
   _____

3. **Allergies (specify substance and reaction):**
   _____

4. **Medications (specify dose, frequency; include over-the-counter, supplements)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. **Heart/Vascular History**: *check and if applicable specify date / detail*

CONDITION	YES	NO	DATE/DETAIL
High Blood Pressure			
High Cholesterol			
Diabetes			
Congenital Heart Disease (heart defect at birth)			
Rheumatic Fever			

CONDITION	YES	NO	DATE/DETAIL
Coronary Artery Disease (blocked heart artery)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure (weak heart and/or fluid in lungs)			
Valvular Heart Disease (blocked or leaky valves)			
Arrhythmia (ie: afib)			
Cardiac Surgery / Procedure			
Cerebrovascular Disease (stroke, carotid blockage)			
Peripheral Vascular Disease (leg or arm blockage)			
Aneurysm			
Deep Vein Thrombosis / Pulmonary Embolism (leg / lung clots)			
Vascular Surgery / Procedure			

6. **Family History**: do your parents and/or siblings have heart and/or vascular disease? If so please specify the problem and age it started:
   Father:_____
   Mother:_____
   Sibling(s):_____

7. **Lifestyle:**
   a. **Have you ever smoked?** (if yes, specify how much and for how many long):
      _____
   b. **Do you drink alcohol?** (if yes, specify how much and how frequently):
      _____
   c. **Do you use drugs?** (if yes, specify type and how frequently):
      _____

8. **Occupation:** _____

9. **Marital status:**
   - ☐ Single
   - ☐ Married
   - ☐ Widowed
   - ☐ Divorced

10. **Residence: with whom do you live?**
    - ☐ Spouse
    - ☐ Alone
    - ☐ Other (please specify): _____

11. **Education Level:** (specify highest level): _____

12. **Children:** (specify number, age(s)): _____

13. **Surgeries:** (specify prior operations/surgeries with date):

_____
_____
_____
_____
_____

14. **Prior Testing:** (if applicable)

Last / Prior Stress Test	Date: _____
Last / Prior Echocardiogram (ultrasound)	Date: _____
Last / Prior Cardiac Catheterization	Date: _____

15. **Other Past Medical History:**
    Please list ***other (non-cardiac/vascular)*** medical problems not identified above:

_____
_____
_____
_____
_____
_____
_____
_____
_____

16. Are you experiencing or have you recently experienced any of the following?

- ☐ Activity Change
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Vision change
- ☐ Snoring
- ☐ Room spinning (vertigo)
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath at rest
- ☐ Shortness of breath on exertion
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Chest pain/discomfort
- ☐ Sweating
- ☐ Palpitations (racing/irregular heart beat)
- ☐ Shortness of breath lying flat
- ☐ Wake up short of breath
- ☐ Passing out / Loss of consciousness
- ☐ Near passing out / near fainting
- ☐ Leg swelling
- ☐ Varicose veins
- ☐ Pain in the legs
- ☐ Leg/foot ulcer/wound
- ☐ Vomiting blood
- ☐ Blood in the stool
- ☐ Acid reflux (heart burn)
- ☐ Blood in the urine
- ☐ Difficulty urinating
- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Skin sore or ulcer
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Easy bleeding
- ☐ Temperature intolerance (hot or cold)
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Tremor(s)
- ☐ Depression
- ☐ Anxiety
- ☐ Increased stress
- ☐ Dizziness
- ☐ Seizures
- ☐ Memory loss
- ☐ Drooping of the face
- ☐ Difficulty with balance
- ☐ Confusion
- ☐ Paralysis
- ☐ Numbness of limbs
- ☐ Slurred speech

HeartPlace
The Future Of Cardiology Is Here

Patient Questionnaire
Are you at risk for Peripheral Artery Disease?

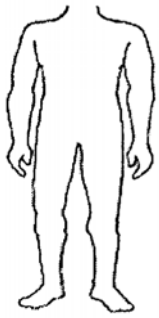
Name:_____ Date:_____

Peripheral artery disease (PAD) is a common circulation problem in which the blood vessels, which carry blood to the legs or arms, become narrow or clogged. Please fill out this questionnaire to see if you have symptoms of Peripheral Artery Disease. Circle Yes or No to the following questions:

1. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks? **Yes** **No**

2. If you answered yes, does the pain subside with rest? **Yes** **No**

   If applicable, circle the area of the body on the diagram below where you feel pain:



3. Do you have any painful sores or ulcers on your legs or feet that aren't healing? **Yes** **No**

4. Do you have (circle all that apply):

   Diabetes High Cholesterol History of Smoking High Blood Pressure

If you have answered yes to any of the above you may be at risk for PAD.

PHYSICIAN ONLY:

☐ Lower Extremity Arterial Duplex (ABI) ☐ CTA

☐ Vascular Consult ☐ Patient Not A Candidate For Further Screening

ICD Codes:
Claudication unspec..PVD 443.9
PVD unspec. 443.9
Ulceration athero. of extr. 440.23
Claudication intermittent with Atherosclerosis 440.21
Athero. of Aorta 440.0
Rest pain athero. of extremities 440.22