www.heartplace.com

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