New Patient Medical Questionnaire

DATE: ______________

Patient Name: ______________________________________ DOB: ______________AGE: ________________

Primary Care Physician: ______________________________________City / State: ____________________________

Other Physicians: ____

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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New Patient Medical Questionnaire

DATE: ______________

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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New Patient Medical Questionnaire

DATE: ______________

Patient Name: ____________________________________ DOB: ______________AGE: ________________

CARDIAC PROCEDURES/DIAGNOSTIC TESTING ☐ Yes ☐ No

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

		Procedure	Year	Location
☐ Yes	☐ No	Echo (Cardiac 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	____________	________________________________

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 _______________________

FEMALE REPRODUCTIVE: ☐ Not Applicable

☐ **Yes** ☐ **No** Multiple miscarriages____________________

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

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

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New Patient Medical Questionnaire

DATE: ______________

Patient Name: ____________________________________ DOB: ______________AGE: ________________

ENDOCRINE:

☐ **Yes** ☐ **No** Thyroid Disorder ________________________

☐ **Yes** ☐ **No** Adrenal Disorder ________________________

OTHER:

☐ **Yes** ☐ **No** Anemia ______________________________

☐ **Yes** ☐ **No** Clotting Disorder________________________

☐ **Yes** ☐ **No** Arthritis ______________________________

☐ **Yes** ☐ **No** HIV_________________________________

☐ **Yes** ☐ **No** Reaction to iodine contrast_________________

☐ **Yes** ☐ **No** Reaction to shrimp or shellfish______________

☐ **Yes** ☐ **No** Hearing Loss___________________________

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

☐ **Yes** ☐ **No** Bleeding Disorder _______________________

☐ **Yes** ☐ **No** Gout _________________________________

☐ **Yes** ☐ **No** Ambulate with assistance__________________

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

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

☐ **Yes** ☐ **No** Vertigo_________________________________

☐ **Yes** ☐ **No** Vision loss_____________________________

☐ **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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New Patient Medical Questionnaire

DATE: ______________

Patient Name: ____________________________________ DOB: ______________AGE: ________________

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

DATE: ______________

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:			
☐ 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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New Patient Medical Questionnaire

DATE: ______________

Patient Name: _____________________________________ DOB: ______________AGE: ________________

FAMILY HISTORY ☐ Adopted

Please indicate below if your FATHER, MOTHER, SIBILING(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

DATE: ______________

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	☐	☐

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New Patient Medical Questionnaire

DATE: ______________

Patient Name: ____________________________________ DOB: ______________AGE: ________________

CURRENT CARDIAC SYMPTOMS (circle all that apply)

1. Do you experience any chest pain, pressure or discomfort? YES NO

a. **Approximate Date of first episode**: _________________ **Approximate Date of last episode:** __________________

b. **Frequency (on average):** _____________ times per day / week / month / year

c. **Frequency status**: less frequent / more frequent / no change(stable)

d. **Duration** (on average per episode): _____________ seconds / minutes / hours / days / weeks

e. **Duration status**: progressively longer / progressively shorter / no change(stable)

f. **Pattern**: continuous / waxing/waning / intermittent / on/off

g. **Location**: Under the sternum(breast bone) / along the sternum / left chest / right chest /
Left arm / right arm / jaw / neck / epigastric area (over stomach) / Other:_____________

h. **Radiate (travel) to another area**: Does not radiate / left arm / right arm / neck / jaw / shoulders / back / Other:

i. **Quality:** dull / burning / aching / sharp / tightness / pressure / squeezing / Like previous angina
Unlike previous angina / Other: _________________________

j. **Severity**(circle one): 1(minor) 2 3 4 5 6 7 8 9 10 (intense)

k. **Severity status**: better / worse / no change / more nitro

l. **Context:** sleep / at rest / stress / at work / exercise / movement
specific activity (type) ____________________________Other: __________________________

m. **Relieving factors**: nothing / rest / Nitroglycerin-under tongue / Nitroglycerin-IV / oxygen / deep breath
/ narcotic medications / non-narcotic pain medications food / antacids / belching
change in position(type?) ______________________ / Other:____________________

n. **Aggravating factors**: Nothing / inspiration(deep breath) / lying down / sitting up
Exertion (type?) ___________________ / stress(type?) ________________ /
Movement(type?) ________________ / meals / exposure to cold / Other: ____________________

o. **Associated factors**: None / nausea / vomiting / belching / sweats / palpitations
Dizziness / lightheadedness / shortness of breath / Other:_________________

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New Patient Medical Questionnaire

DATE: ______________

Patient Name: ______________________________________ DOB: ______________AGE: ________________

2. Do you experience any shortness of breath NOT associated with chest pain? YES NO

a. **Approximate Date of first episode:**________________ **Approximate Date of last episode:** ______________

b. **Frequency** (on average): ______________times per / day / week / month / year

c. **Frequency status?** More frequent / less frequent / no change

d. **Duration** (on average per episode)?________ minutes / hours / days

e. **Duration status?** Progressively longer / progressively shorter / no change

f. **Mode of onset?** gradual / sudden

g. **Severity?** Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe

h. **Severity status?** Better / worse / no change

i. **Context(When do you get short of breath?):** At Rest / stress / with activity (what type?)________________

j. **How far can you walk before you get short of breath?** ________________ yards / blocks / miles

k. **Do you need to sleep on more than 1 pillow to breathe?** NO / YES, How many pillows? _____________

l. **Do you wake up in the middle of the night short of breath?** NO / YES, How often? ___________________

m. **Relieving factors:** Nothing / fresh air / nebulizers / nitroglycerin / rest / oxygen / sitting / inhalers / medications oral prednisone / Other: _________________

n. **Aggravating factors:** Nothing / anxiety/ stress / normal activities / bending forward / mild activity(walking) moderate activity (climbing stairs) / strenuous activity(running) / laying flat/ upper extremity activity/ Other:___________________

o. **Associated symptoms**: none / anxiety / chest pain / cough / fever / leg swelling / sputum wheezing / palpitations / lightheaded / other:___________________

1. Do your legs swell? YES NO

a. **Approximate Date of first episode:** ____________ **Approximate Date of last episode:** _____________

b. **Frequency**(on average): ___________________________ times per / week / month / year

c. **Duration:**(on average) ______________________ hours / days / weeks / months

d. **Severity:** Minimal / mild / mild to moderate / moderate / moderate to severe / severe

e. **What is the location of the swelling**: Foot / ankle / calf / knee / thigh / other:_______________

f. **Context(when do your legs swell?):** Nothing / laying flat / sitting / standing / walking / other:_________

g. **What relieves the swelling**: Nothing compression stockings / leg elevation / lying flat / sitting / walking

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New Patient Medical Questionnaire DATE: _____________

Patient Name: ____________________________________ DOB: _____________AGE: _______________

h. **Associated symptoms**: None / unusual weight gain / skin discoloration / ulcers / shortness of breath

4. Do you experience any palpitations (rapid heart beat or skipped beats)? YES NO

a. **Quality:** rare skipped beats / occasional skipped beats / frequent skipped beats / flutter
sustained / regular / irregular / rapid heartbeat / other: ___________________

b. **Approximate Date of first episode:** ________________ **Approximate Date of last episode:** _________________

c. **Frequency of palpitations**(on average):_____________________ times per day / week / month / year

d. **Frequency Status:** more frequent / less frequent / no change/stable

e. **Duration (per episode)**: _________________________ seconds / minutes / hours / days

f. **Duration status:** longer / shorter / no change

g. **Severity**: Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe

h. **Severity status:** increasing / decreasing / no change/stable

i. **Context:** None / sleep / rest / exertion(type?)________________ / other:___________________

j. **Aggravating factors:** None / anxiety / stress / caffeine / alcohol / Sudafed /
other-medications(type?)________________________ / Other: ___________________

k. **Relieving factors**: None / cough / neck massage / bearing-down / cold water to face
Exertion (type?) ___________ / medications (type?)________________ / other:______________

l. **Associated symptoms:** None / shortness of breath / chest pain / dizziness / lightheadedness
near-fainting / fainting / other:_______________________

5a. Have you ever fainted (with loss of consciousness)? YES NO

5b. Have you ever felt dizzy or like you were going to faint or pass out YES NO

a. **Quality** (circle all that apply): floating / imbalance / lightheadedness / spinning
unstable horizon / loss of consciousness(fainted)

b. **Approximate Date of first episode:** _______________ **Approximate Date of last episode:** ________________

c. **Frequency**: ___________________ times per day / week / month / year

d. **Frequency status:** more frequent / less frequent / no change/stable

Reviewed By: __________________________

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New Patient Medical Questionnaire DATE: ______________

Patient Name: ______________________________________ DOB: ______________AGE: ________________

e. **Duration** (on average): ______________________seconds / minutes / hours / days

f. **Context:** no warning / sitting to standing / abdominal pain/cramping / coughing / chest pain / other pain / nausea / palpitations / shortness of breath / ringing in ears / urination / bowel movement blood draw / fasting / vertigo / other:___________________

g. **Aggravating factors**: none / dehydration / change of position(type?)_______________ / head turning exercise(type?)________________________ / medications (type?)____________________ other:______________

h. **Relieving factors**: none / lying down / sitting / rest / medications (type?)________________ Other:______________________

i. **Associated symptoms**: none / confusion / seizure / seizure-like activity / headache slurred speech / visual changes / weakness / chest pain / palpitations / shortness of breath / other:_________________________

6. <u>Any other reason why you need to see a cardiologist?</u>

____

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Thank you for taking the time to complete this questionnaire.

Patient Signature ________________________________

Reviewed By: ______________________

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