



# Cardiology Questionnaire

## PATIENT HISTORY FORM

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Appointment Date: \_\_\_\_\_ Appointment Time \_\_\_\_\_ Soc. Security Number: \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Other Physician (if any) \_\_\_\_\_  
 Presenting problem (reason for your visit) \_\_\_\_\_

### Current Medications

(including aspirin, vitamins, antacids, eye drops, laxatives, herbal medicines, etc.)

<u>Drug Name</u>	<u>Tablet size (e.g., 5 mg)</u>	<u># of tablets taken at a time</u>	<u># of times per day you take &amp; when</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
15. _____	_____	_____	_____

Do you have **ALLERGIES TO IODINE**, seafood or x-ray contrast dye?

No  Yes  Describe \_\_\_\_\_

Do you have **ALLERGIES or Reactions** to any other medication? No  Yes  (Describe below)

<u>Drug Name</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____

### Cardiac Risk Factors

Have you ever used tobacco? No  Yes  (Complete below)  
# of packs\_\_\_\_ or cans of chew\_\_\_\_ per day. How many years? \_\_\_\_ Stopped when?\_\_\_\_\_

Do you have high cholesterol? No  Yes  Controlled with meds  Don't know

Do you have high blood pressure? No  Yes  Controlled with meds  Don't know

Do you have diabetes? No  Yes  Borderline (diet controlled)

Have you ever had a heart attack, angioplasty (balloon procedure) or stent, bypass surgery, or been told you have blocked arteries? No  Yes

### Cardiac History

Have you ever had any previous cardiac tests? No  Yes  (Complete below)

Date(s) and location(s)

Stress test (treadmill, etc.)\_\_\_\_\_

Echocardiogram (heart ultrasound)\_\_\_\_\_

Holter monitor (day-long EKG)\_\_\_\_\_

Heart CAT scan\_\_\_\_\_

Heart catheterization\_\_\_\_\_  
(angiogram, dye injection in heart arteries)

Electrophysiology Study\_\_\_\_\_  
(electrical stimulation by wires in the heart)

Have you ever had any of the following? No  Yes  (Complete below)

Date(s) and location(s)

Heart attack\_\_\_\_\_

Angioplasty or stenting of heart arteries\_\_\_\_\_

Angioplasty or stenting of other arteries-e.g. neck, legs, etc. (describe)\_\_\_\_\_

Heart bypass surgery\_\_\_\_\_

Surgery on other arteries (describe)\_\_\_\_\_

Heart valve or other heart surgery\_\_\_\_\_

Cardioversion (shocking heart back to normal rhythm)\_\_\_\_\_

Pacemaker\_\_\_\_\_

Implanted defibrillator\_\_\_\_\_

Surgery on varicose veins\_\_\_\_\_

Congestive Heart Failure (fluid around the heart)\_\_\_\_\_

Atrial Fibrillation\_\_\_\_\_

**Past Medical History**

Have you had any significant infections or childhood illnesses? No  Yes  (Complete below)

Describe

Date(s) and location(s)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

When was your last hospitalization? \_\_\_\_\_ For what reason? \_\_\_\_\_

**Social History**

Do you drink any alcohol? No  Yes  (Complete below)

What is your typical consumption:

# glasses wine \_\_\_\_\_ # bottles beer \_\_\_\_\_ oz. liquor \_\_\_\_\_ in a (check one): day  week  year

Typically, what is the most you will drink at one time? \_\_\_\_\_

Have you reduced or stopped drinking recently? No  Yes  If so, when? \_\_\_\_\_

Do you follow a special diet? No  Yes  Describe \_\_\_\_\_

Do you exercise regularly? No  Yes  (Complete below)

Type of exercise \_\_\_\_\_ Intensity: Mild  Moderate  Intense

Duration of exercise in minutes \_\_\_\_\_ Typically how often per week \_\_\_\_\_

Do you have a history of alcohol or drug abuse? No  Yes  Describe \_\_\_\_\_

What is the highest level of education you achieved? \_\_\_\_\_

Are you: Single  Divorced  Living w/ a partner  Married  Widowed

What is or was your predominant occupation? \_\_\_\_\_

Are you working: Full time  Part time  Unemployed  Retired  Disabled

What type of residence do you live in? (i.e. house, appt, assisted living) \_\_\_\_\_

Who else lives with you? (i.e., spouse, children, parents) \_\_\_\_\_

What town or community do you live in or near to? \_\_\_\_\_

**Family History**

**Has anyone in your immediate family had a heart attack, angioplasty (balloon procedure) or stent, bypass surgery, or been told they had blocked arteries?** No  Yes  (Complete below)

Age of first problem

Describe

- |  |       |       |
|--|-------|-------|
| <input type="checkbox"/> Father                        | _____ | _____ |
| <input type="checkbox"/> Mother                        | _____ | _____ |
| <input type="checkbox"/> Brother/Sister (circle which) | _____ | _____ |
| <input type="checkbox"/> Brother/Sister (circle which) | _____ | _____ |
| <input type="checkbox"/> Brother/Sister (circle which) | _____ | _____ |
| <input type="checkbox"/> Brother/Sister (circle which) | _____ | _____ |
| <input type="checkbox"/> Son/Daughter (circle which)   | _____ | _____ |

**List Any Other Surgeries, include the date performed.**

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1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Has anyone in your immediate family had any of the following problems?**

Relationship and age of onset

- Sudden, unexplained death \_\_\_\_\_
- Unexplained passing out spells \_\_\_\_\_
- Heart rhythm problems \_\_\_\_\_
- Heart failure or weakened heart \_\_\_\_\_
- Aneurysm of the aorta \_\_\_\_\_
- Aneurysm of the brain \_\_\_\_\_
- Stroke \_\_\_\_\_
- Congenital heart disease (birth defect) \_\_\_\_\_
- Heart surgery other than above \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Bleeding disorder \_\_\_\_\_

**Review Of Cardiovascular System**

**Respiratory**

- Do you have problems with shortness of breath?  No  Yes
- Do you get short of breath when lying down or wake up short of breath?  No  Yes
- Do you have a chronic cough or wheeze? (circle which)  No  Yes
- Have you ever coughed up blood?  No  Yes
- Are you a heavy snorer or do you ever fall asleep inappropriately (e.g., while driving)?  No  Yes
- Has anyone told you that you stop breathing while sleeping?  No  Yes
- Describe any other respiratory problems \_\_\_\_\_

**Cardiovascular**

- Do you get chest pain, tightness, or pressure?  No  Yes
- Have you had palpitations or rapid, irregular heart beats?  No  Yes
- Have you ever lost or almost lost consciousness?  No  Yes
- Do you get pain or cramps in your legs **when you walk**?  No  Yes
- Do you have a history of blood clots in your legs?  No  Yes
- Do you get significant swelling in your legs?  No  Yes
- Describe any other cardiovascular problems \_\_\_\_\_