Cardiology Patient Questionnaire

<table>
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<tr>
<th>Patient Name</th>
<th>Birth Date</th>
<th>S</th>
<th>M</th>
<th>D</th>
<th>W</th>
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<tr>
<th>Occupation</th>
<th>Primary Care Physician</th>
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**Problem[s] to be evaluated:**

First noticed symptoms: Date: ___________ or ___ number of [ ] days [ ] weeks [ ] months [ ] years ago

Frequency of symptoms: ___________ number of times per [ ] hour [ ] day [ ] week [ ] month [ ] year

My symptoms are: [ ] None [ ] Very Mild [ ] Mild [ ] Moderate [ ] Severe

My symptoms last for: ___________ [ ] seconds [ ] minutes [ ] hours [ ] days [ ] constantly

Does this problem occur at a specific time? [ ] No [ ] Yes, if yes, specify _______________________

Where are you or what are you doing when the problem occurs? _______________________

What makes the problem better? _______________________

What makes the problem worse? _______________________

Any previous occurrences? _______________________

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Which of the following symptoms have you experienced recently [where appropriate circle or check]:

Chest discomfort: Location __________________ Moves into: (arm, neck, jaw, back, or other): ___________

Quality (lightness, burning, pressure, aching, sharp, stabbing, other) ______________________

This occurs with: exercise, rest, deep breathing, coughing, lying down, or other: ______________________

Trouble breathing: Worse with: [ ] lying down flat [ ] rest [ ] exercise [ ] during chest discomfort

I sleep: [ ] flat [ ] one pillow [ ] two or more pillows

I wake up at night feeling stuffy or with a need for more air: [ ] No [ ] Yes

Swelling: [ ] None [ ] Ankles or Feet [ ] Hands [ ] Generalized

Irregular heartbeats or palpitations:

[ ] I have [ ] I have not, noticed lightheadedness, dizziness, or feelings that I could pass out.

[ ] I have [ ] I have not, passed out or lost consciousness.

Discomforts in my leg muscles, calves, or buttocks when I walk or exercise: [ ] No [ ] Yes

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I can walk for: [ ] ____ miles [ ] 1 mi [ ] ½ mi [ ] ¼ mi [ ] few blocks [ ] 1 block or less before stopping.

My activities are limited by: [none, chest discomfort, breathing problem, muscle/joint pain, other pain].

Numbness of extremities or loss of vision or speech? [ ] No [ ] Yes

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**Preferently known heart/vascular problems?**

[ ] Rheumatic Fever [ ] Heart Murmur [ ] Arrhythmia [ ] Heart Problem from birth

[ ] Heart failure, if yes, fluid in lungs? [ ] No [ ] Yes [ ] Other ______________________________

[ ] Pacemaker [single or dual chamber] Date of implant: ___________ Manufacturer: ________________

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□ Aneurysm: □ Brain □ Chest □ Abdomen | Surgery: □ No □ Yes | Size of aneurysm: ________
Heart attack, angina or chest pain evaluation? [how many, approximate dates, where performed]:
Stress test: ____________________________________________
Angiogram or heart catheter: _______________________________________
Angioplasty/stents: _____________________________________________
Bypass surgery: ___________________________________________ Number of vessels bypassed: _____
Hospitalizations/Emergency Room visits for heart problems or other heart surgery:
How many and which hospital[s]?:
________________________________________
________________________________________
________________________________________
Strokes or TIAs (mini-strokes): □ No □ Yes | How many? __________
Affected my: □ Face □ Speech □ Arm □ Leg □ Vision | Which side: □ Left □ Right

My risk factors for heart disease: □ High blood pressure □ Diabetes □ High Cholesterol
□ Smoking □ Lack of routine exercise □ Any family history of premature heart attack or sudden death

Other Medical History [check all that apply]:
□ Anemia □ Bronchitis or other lung problems □ Thyroid problems
□ Cancer □ Ulcers □ Seizures
□ TB □ Yellow jaundice/hepatitis □ Arthritis (degenerative, rheumatoid)
□ Valley Fever □ Intestinal bleeding □ Gout
□ Phlebitis □ Irritable bowel □ Prostate
□ Blood clot to lung □ Pancreatitis □ Kidney stones
□ Sleep apnea □ Gallbladder □ Dialysis
□ Emphysema □ Urinary infections □ Headaches (migraine or tension)
□ Pneumonia □ Venereal diseases □ HIV or AIDS
□ Bronchitis or other lung problems

Other hospitalizations/Surgeries: (give year and type, include inpatient and outpatient)

________________________________________
________________________________________
________________________________________

Trauma/Injuries: (year and type)

Medication Allergy / Adverse side effects: (List the name and side effect)

________________________________________

Iodine Allergy?: __________ Food, pollen, hay fever, or seasonal allergies?: __________

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Habits:
Smoking (never, past, present) (circle one)
I smoke(d) ____ packs of cigarettes / cigars per day for __ years. I quit ______(date).
Alcohol: (never, past, present) (circle one) I drink ____ (bottles, glasses, ounces) of beer, wine, liquor
Per (day, week, month, year). I stopped drinking _________________.
Caffeine: I drink ____________ (cups, cans) of (coffee, tea, cola) (day, week, month).
Drug Use: I have, have never) used illicit drugs: Specify: ________________________________

<table>
<thead>
<tr>
<th>Family History:</th>
<th>Age(s)</th>
<th>Diseases</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>_____</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>_____</td>
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<td>Brothers</td>
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<td>Sisters</td>
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<tr>
<td>Others</td>
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</tbody>
</table>

Other symptoms I have recently experienced that are not included above: (circle any that apply)

General: fevers, chills, fatigue, weight loss, weight gain, fall asleep inappropriately or inability to sleep
Eyes: visual problems, ears, nose, mouth, throat: hearing loss, bleeding of nose or gums, loud snoring, _____
Respiratory: cough, phlegm, wheezing, spitting up blood, exposure to second hand smoke or fumes
Stomach or Bowel: abdominal pain, heartburn, nausea, vomiting, diarrhea, constipation, dark black or bloody stools
Genitourinary: blood in urine, frequent urination, stress incontinence, pain, impotence _______________
Gynecology: (pregnant, menstruating, menopausal). Last menstrual period ____________________________
Skin and Breasts: rashes or breast pain, lumps, or swelling ________________________________
Neurology: headaches, shaking, numbness, sciatica, weakness, memory loss or confusion ___________
Musculoskeletal: muscle or joint pain, back problems, difficult), walking ___________________________
Psychiatric: anxiety/depression, psychiatric illness _____________________________
Hematologica/Lymphatic: excessive bleeding or easy bruising, previous transfusions, lumps or growths_____
Endocrine: gland or hormone problems, heat or cold intolerance, excessive thirst ______________________

Other Comments/Questions to give to the doctor:
________________________________________
________________________________________
________________________________________
________________________________________

Personal/religious convictions: example: In an emergency I (will, will not) accept blood transfusions for surgery,
Others: _______________________________ Special Directives: Living Will? (yes no)

Completed by: (patient, other) _______________________________ (state relationship)

Signature: _______________________________ Date: ____________________

Reviewed: _______________________________ Date: ____________________

Darrell D. Walter, M.D., FACC

PT. LABEL (REQUIRED ON PAGE 1 ONLY)