Cardiology Patient Questionnaire

Patient Name _____ Birth Date _____ (age) _____ S M D W Marital Status *[circle one]*

Occupation _____ Primary Care Physician _____

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? _____ Worse? _____

Any previous occurrences? _____

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): _____

Qualiity (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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Previously 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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PT. LABEL (REQUIRED ON PAGE 1 ONLY)

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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
☐ Asthma	☐ Urinary infections	☐ Headaches (migraine or tension)
☐ Emphysema	☐ Venereal diseases	
☐ Pneumonia	☐ HIV or AIDS	

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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PT. LABEL (REQUIRED ON PAGE 1 ONLY)

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: _____

Family History:	**Age(s)**	**Diseases**	**If deceased, cause of death)**
Mother	____	_____	_____
Father	____	_____	_____
Brothers	____	_____	_____
Sisters	____	_____	_____

Others _____

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: _____

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