

# NEW PATIENT QUESTIONNAIRE

## I. PATIENT INFORMATION

Today's Date: \_\_\_\_\_ Patient MR#: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI (Jr, Sr. etc.)

Date of Birth: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Referred By: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

## II. CHIEF COMPLAINT THAT BRINGS YOU HERE TODAY

\_\_\_\_\_

## III. CURRENT MEDICATION (INCLUDE OVER-THE-COUNTER AND HERBAL SUPPLEMENTS)

30 day supply or  90 day supply

Drug / Dose / Frequency

Drug / Dose / Frequency

1. \_\_\_\_\_

11. \_\_\_\_\_

2. \_\_\_\_\_

12. \_\_\_\_\_

3. \_\_\_\_\_

13. \_\_\_\_\_

4. \_\_\_\_\_

14. \_\_\_\_\_

5. \_\_\_\_\_

15. \_\_\_\_\_

6. \_\_\_\_\_

16. \_\_\_\_\_

7. \_\_\_\_\_

17. \_\_\_\_\_

8. \_\_\_\_\_

18. \_\_\_\_\_

9. \_\_\_\_\_

19. \_\_\_\_\_

10. \_\_\_\_\_

20. \_\_\_\_\_

**IV. MEDICATION ALLERGIES** \_\_\_\_\_

(Food / X-ray dye / Seafood / Other) \_\_\_\_\_

**V. CARDIOVASCULAR HISTORY**

- | Yes                      | No                       |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath      |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg swelling             |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat     |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy spells             |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack             |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps while walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in feet/legs    |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____              |

**VI. PRIOR CARDIAC PROCEDURES**

- | Yes                      | No                       |  | (List date and location) |
|--------------------------|--------------------------|--|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Balloon angioplasty or stent of coronaries | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Coronary bypass surgery                    | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Valve surgery                              | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker                                  | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrophysiology study                    | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Ablation                                   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | ICD (defibrillator)                        | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular surgery (legs, carotids)          | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrical cardioversion                   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                                | _____                    |

**VII. PRIOR CARDIAC TESTS**

- | Yes                      | No                       |   | (List date and location) |
|--------------------------|--------------------------|---|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Treadmill   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Nuclear study (Thallium, Myoview, Cardiolite)   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Echocardiogram (Heart ultrasound)   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Holter monitor/Event Recorder   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | EKG/ECG (electrocardiogram)   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac catheterization   | _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular ultrasound study   | _____                    |
|                          |                          | <input type="checkbox"/> Carotids (neck) <input type="checkbox"/> Legs <input type="checkbox"/> Other _____ |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____   | _____                    |

**VIII. CARDIAC RISK FACTORS**

- Cigarette smoker
- Ex-smoker
- High blood pressure
- High cholesterol/triglycerides
- Diabetes
- Over-weight
- Family history of heart disease

**IX. PERSONAL HISTORY**

Marital status            S   M   D   (Circle one)  
 Smoker                    \_\_\_\_\_pack/day  
 Alcohol                    \_\_\_\_\_number/day  
 Caffeine                   \_\_\_\_\_cups/day  
 Exercise                  \_\_\_\_\_never    \_\_\_\_\_rare    \_\_\_\_\_occasional    \_\_\_\_\_regular

Special Diet \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Retired    Yes     No

**X. FAMILY HISTORY**

	Living Heart-Related Health Problems	Age Deceased & Cause of Death
Father		
Mother		
Siblings		
Children		

## XI. PAST MEDICAL HISTORY

A) SURGERIES (List and Date)

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B) PAST ILLNESSES

- |   |  |
|---|--|
| <input type="checkbox"/> Alzheimer's            | <input type="checkbox"/> Gout            |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Aneurysm               | <input type="checkbox"/> Hiatal hernia   |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Kidney          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Liver           |
| <input type="checkbox"/> Bladder problem        | <input type="checkbox"/> Parkinson's     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Prostate        |
| <input type="checkbox"/> Carotid artery disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Colon disease          | <input type="checkbox"/> Stomach ulcers  |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> TB              |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Esophageal disease     |  |

## XII. REVIEW OF SYSTEMS

- | Yes                      | No                       | Recent                   |                             | Yes                      | No                       | Recent                   |                          |
|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Panic Attacks       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptoms      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscles/Joints/Bones        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/Vomiting/Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine or stool     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nose bleed               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis/Tremors        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart/Circulation           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent weight change     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Easy bleeding/bruising      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever/Chills                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination at night | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visual problems          |

07/03