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.

			Year	Location
☐ Yes	☐ No	Echo (Heart 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	___________	______________________________

LAB WORK: Month & Year of most recent? __________________________ Location? ________________________

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** Bronchitis ___________________________
☐ **Yes** ☐ **No** Emphysema / COPD ____________________ ☐ **Yes** ☐ **No** Tuberculosis ________________________
☐ **Yes** ☐ **No** Pneumonia ___________________________ ☐ **Yes** ☐ **No** Sleep Apnea _________________________

GASTROINTESTINAL:

☐ **Yes** ☐ **No** Reflux(GERD)__________________________ ☐ **Yes** ☐ **No** Hiatal Hernia ________________________
☐ **Yes** ☐ **No** Diverticulosis / Diverticulitis _______________ ☐ **Yes** ☐ **No** Ulcers ______________________________
☐ **Yes** ☐ **No** Liver Disease / Hepatitis _________________ ☐ **Yes** ☐ **No** Gastritis ____________________________
☐ **Yes** ☐ **No** Gallbladder Disease / Gallstones ____________ ☐ **Yes** ☐ **No** Gastrointestinal Bleed __________________

RENAL / GENITOURINARY:

☐ **Yes** ☐ **No** Dialysis _____________________________ ☐ **Yes** ☐ **No** Prostate Disease _____________________
☐ **Yes** ☐ **No** Kidney Stones _________________________ ☐ **Yes** ☐ **No** Kidney Disease / Elevated Creatinine ________

NEUROLOGICAL / PSYCHOLOGICAL:

☐ **Yes** ☐ **No** Intracranial (in the brain) Bleeding __________ ☐ **Yes** ☐ **No** Seizure Disorder _______________________
☐ **Yes** ☐ **No** Migraine Headaches ___________________ ☐ **Yes** ☐ **No** Dementia ____________________________
☐ **Yes** ☐ **No** Depression ___________________________ ☐ **Yes** ☐ **No** Anxiety Disorder ______________________

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Patient Name: _____________________________________ DOB: ______________AGE: ________________

FEMALE REPRODUCTIVE: ☐ **Not Applicable**

☐ **Yes** ☐ **No** Multiple miscarriages________________________

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

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

ENDOCRINE:

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

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

OTHER:

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

☐ **Yes** ☐ **No** Bleeding Disorder ______________________

☐ **Yes** ☐ **No** Clotting Disorder_________________________

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

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

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

☐ **Yes** ☐ **No** HIV___________________________________

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

☐ **Yes** ☐ **No** Reaction to iodine contrast__________________

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

☐ **Yes** ☐ **No** Vertigo________________________________

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

☐ **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, SIBLING(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	☐	☐

CARDIAC:	YES	NO
Chest pain	☐	☐
Chest pressure	☐	☐

	YES	NO
Shortness of breath	☐	☐
Difficulty breathing while laying flat	☐	☐
Awakening with breathing difficulty	☐	☐

	YES	NO
Swelling in feet/ankles	☐	☐

	YES	NO
Palpitations	☐	☐

	YES	NO
Nearly passing out spells	☐	☐
Passing out spells	☐	☐

Any other reason why you need to see a cardiologist?

____
____
____
____
____
____
____
____
____

Thank you for taking the time to complete this questionnaire.

Patient Signature ______________________________

Reviewed By: ______________________

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