New Patient Medical Questionnaire

DATE: _____/_____/_____

Patient Name:_____DOB:_____AGE: _____

Primary Care Physician:_____City/State: _____

Other Physicians: _____

Pharmacy:_____City/Intersection/Phone:_____

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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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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CARDIAC PROCEDURES/DIAGNOSTIC TESTING ☐ Yes ☐ No

Please check that you have had or have not had any procedures / diagnostic tests. Write the year / location of the test in the blanks 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** Emphysema / COPD _____
☐ **Yes** ☐ **No** Pneumonia _____
☐ **Yes** ☐ **No** Bronchitis _____
☐ **Yes** ☐ **No** Tuberculosis _____
☐ **Yes** ☐ **No** Sleep Apnea _____

GASTROINTESTINAL:

☐ **Yes** ☐ **No** Reflux(GERD)_____
☐ **Yes** ☐ **No** Diverticulosis / Diverticulitis _____
☐ **Yes** ☐ **No** Liver Disease / Hepatitis _____
☐ **Yes** ☐ **No** Gallbladder Disease / Gallstones _____
☐ **Yes** ☐ **No** Hiatal Hernia _____
☐ **Yes** ☐ **No** Ulcers _____
☐ **Yes** ☐ **No** Gastritis _____
☐ **Yes** ☐ **No** Gastrointestinal Bleed _____

RENAL / GENITOURINARY:

☐ **Yes** ☐ **No** Dialysis _____
☐ **Yes** ☐ **No** Kidney Stones _____
☐ **Yes** ☐ **No** Prostate Disease _____
☐ **Yes** ☐ **No** Kidney Disease / Elevated Creatinine _____

NEUROLOGICAL / PSYCHOLOGICAL:

☐ **Yes** ☐ **No** Intracranial (in the brain) Bleeding _____
☐ **Yes** ☐ **No** Migraine Headaches _____
☐ **Yes** ☐ **No** Depression _____
☐ **Yes** ☐ **No** Seizure Disorder _____
☐ **Yes** ☐ **No** Dementia _____
☐ **Yes** ☐ **No** Anxiety Disorder _____

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New Patient Medical Questionnaire

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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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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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 diet:**			
☐ 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

Patient Name:_____DOB:_____AGE: _____

FAMILY HISTORY ☐ Adopted

Please indicate below if your FATHER, MOTHER, SIBILING(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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