Established Patient Questionnaire

Date: _____

Patient Name: _____,_____ **DOB:** _____ **AGE:** _____

Family physician: _____ **Last seen?:** _____

Other physicians that care for you: _____

Reason for today's visit: routine follow-up hospital follow-up urgent work-in

Chief Complaint (What problems are you here for today?): _____

Last HeartPlace Physician Encounter Date: _____ **Setting:** office hospital ER

Pharmacy: _____ **City/Intersection/Phone:** _____

Since your last visit with us have you had any…?			**Comments**
New illnesses?	❑ Yes	❑ No	_____
Hospitalizations or ER visits?	❑ Yes	❑ No	_____
Surgical procedures?	❑ Yes	❑ No	_____
Drug allergies/reactions?	❑ Yes	❑ No	_____
Started or continued to smoke?	❑ Yes	❑ No	Type, how much, how often? _____
Alcohol consumption?	❑ Yes	❑ No	Type, how much, how often? _____
Caffeine consumption?	❑ Yes	❑ No	Type, how much, how often? _____
Exercise?	❑ Yes	❑ No	Type, how often, how long? _____
Home exercise equipment?	❑ Yes	❑ No	Type? _____
Special diet?	❑ Yes	❑ No	Type? How compliant? _____
Home blood pressure measurement?	❑ Yes	❑ No	Average reading? _____
Blood work done?	❑ Yes	❑ No	When? Where? _____
Cholesterol checked?	❑ Yes	❑ No	When? Where? _____
Medication refills needed?	❑ Yes	❑ No	_____

Since your last visit with us have you experienced any…?

Chest pain or pressure?	❑ Yes	❑ No	Nearly passing out spells?	❑ Yes	❑ No
Shortness of breath?	❑ Yes	❑ No	Passing out spells?	❑ Yes	❑ No
Shortness of breath on exertion?	❑ Yes	❑ No	Recurrent Dizziness?	❑ Yes	❑ No
Difficulty breathing while laying flat?	❑ Yes	❑ No	Weight gain?	❑ Yes	❑ No
Awakening with breathing difficulty?	❑ Yes	❑ No	Weight loss?	❑ Yes	❑ No
Swelling in feet/ankles?	❑ Yes	❑ No	Increased stress?	❑ Yes	❑ No
Palpitations? (heart racing, skipping)	❑ Yes	❑ No			

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Reviewed By: _____