HEARTPLACE PLANO

www.plano.heartplace.com

ESTABLISHED PATIENT QUESTIONNAIRE

NAME: _____DATE OF BIRTH:_____ DATE OF VISIT:_____
EMAIL ADDRESS: _____
PRIMARY CARE PHYSICIAN: _____
OTHER PHYSICIANS (THAT YOU WISH TO RECEIVE RECORDS):_____

Reason for visit:

- ☐ Routine follow-up
- ☐ Hospital follow-up
- ☐ New cardiovascular concern(s) - specify: _____

If you have any NEW drug allergies, please report them here:

Since your last visit, have you experienced any of the following?

- ☐ Activity Change
- ☐ Shortness of breath (rest or with activity)
- ☐ Chest pain/ pressure / discomfort
- ☐ Palpitations (racing/irregular heart beat)
- ☐ Shortness of breath lying flat
- ☐ Waking up short of breath
- ☐ Passing out / Loss of consciousness
- ☐ Leg swelling
- ☐ Varicose veins
- ☐ Leg pain
- ☐ Leg/foot ulcer/wound
- ☐ Bleeding (stool / urine)
- ☐ Easy bleeding / bruising
- ☐ Dizziness / light-headedness

Changes since your last visit:

New diagnosis(es)? (ie: Diabetes, Cancer, Anemia, etc.)_____

Hospitalizations? _____

Surgeries? _____

Outside testing: ☐ Labs ☐ Imaging ☐ Heart / Vascular testing

Cigarette/Tobacco Use: Did you start or continue to smoke? ☐ No ☐ Yes

If yes, how much? ____ packs per ☐ Day ☐ Week

Do you exercise? ☐ No ☐ Yes (please specify):_____

Change in marital status? ☐ No ☐ Yes (please specify):_____

Medications: **To ensure accuracy, please BRING your medications (or a picture of bottles) to all office visits!**