# 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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HeartPlace **New Patient Medical Questionnaire**

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

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 / 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** 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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# HeartPlace 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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# New Patient Medical Questionnaire

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

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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# New Patient Medical Questionnaire

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 | ☐ | ☐ |

**Thank you for taking the time to complete this questionnaire.**

| **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?**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Patient Signature** ______________________________

Reviewed By:______________________________________________


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