New Patient Medical Questionnaire

Patient Name: _____ DOB: _____DATE: _____

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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New Patient Medical Questionnaire

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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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New Patient Medical Questionnaire

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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 and the location of the test in the blank indicated.

			Year	Location
☐ Yes	☐ No	Echo (Cardiac 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	_____	_____

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 _____

FEMALE REPRODUCTIVE: ☐ Not Applicable

☐ **Yes** ☐ **No** Multiple miscarriages_____ ☐ **Yes** ☐ **No** Currently Pregnant (number of weeks?)_____

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

Reviewed By: _____

New Patient Medical Questionnaire

Patient Name: _____ DOB: _____DATE: _____

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** Reaction to shrimp or shellfish_____ ☐ **Yes** ☐ **No** Vertigo_____

☐ **Yes** ☐ **No** Hearing Loss_____ ☐ **Yes** ☐ **No** Vision loss_____

☐ **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: _____DATE: _____

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) _____

Reviewed By: _____

New Patient Medical Questionnaire

Patient Name: _____ DOB: _____DATE: _____

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

Reviewed By: _____

New Patient Medical Questionnaire

Patient Name: _____ DOB: _____DATE: _____

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:

_____

_____

Reviewed By: _____

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	☐	☐

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:_____

New Patient Medical Questionnaire

Patient Name: _____ DOB: _____DATE: _____

CURRENT CARDIAC SYMPTOMS (circle all that apply)

1. Do you experience any chest pain, pressure or discomfort? YES NO

a. **Approximate Date of first episode**: _____ **Approximate Date of last episode:** _____

b. **Frequency (on average):** _____ times per day / week / month / year

c. **Frequency status**: less frequent / more frequent / no change(stable)

d. **Duration** (on average per episode): _____ seconds / minutes / hours / days / weeks

e. **Duration status**: progressively longer / progressively shorter / no change(stable)

f. **Pattern**: continuous / waxing/waning / intermittent / on/off

g. **Location**: Under the sternum(breast bone) / along the sternum / left chest / right chest /

Left arm / right arm / jaw / neck / epigastric area (over stomach) / Other:_____

h. **Radiate (travel) to another area**: Does not radiate / left arm / right arm / neck / jaw / shoulders / back / Other:

i. **Quality:** dull / burning / aching / sharp / tightness / pressure / squeezing / Like previous angina

Unlike previous angina / Other: _____

j. **Severity**(circle one): 1(minor) 2 3 4 5 6 7 8 9 10 (intense)

k. **Severity status**: better / worse / no change / more nitro

l. **Context:** sleep / at rest / stress / at work / exercise / movement

specific activity (type) _____Other: _____

m. **Relieving factors**: nothing / rest / Nitroglycerin-under tongue / Nitroglycerin-IV / oxygen / deep breath

/ narcotic medications / non-narcotic pain medications food / antacids / belching

change in position(type?) _____ / Other:_____

n. **Aggravating factors**: Nothing / inspiration(deep breath) / lying down / sitting up

Exertion (type?) _____ / stress(type?) _____ /

Movement(type?) _____ / meals / exposure to cold / Other: _____

o. **Associated factors**: None / nausea / vomiting / belching / sweats / palpitations

Dizziness / lightheadedness / shortness of breath / Other:_____

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HeartPlace **New Patient Medical Questionnaire**

Patient Name: _____ DOB: _____DATE: _____

2. Do you experience any shortness of breath NOT associated with chest pain? YES NO

a. **Approximate Date of first episode:**_____ **Approximate Date of last episode:** _____

b. **Frequency** (on average): _____times per / day / week / month / year

c. **Frequency status?** More frequent / less frequent / no change

d. **Duration** (on average per episode)?_____ minutes / hours / days

e. **Duration status?** Progressively longer / progressively shorter / no change

f. **Mode of onset?** gradual / sudden

g. **Severity?** Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe

h. **Severity status?** Better / worse / no change

i. **Context(When do you get short of breath?):** At Rest / stress / with activity (what type?)_____

j. **How far can you walk before you get short of breath?** _____ yards / blocks / miles

k. **Do you need to sleep on more than 1 pillow to breathe?** NO / YES, How many pillows? _____

l. **Do you wake up in the middle of the night short of breath?** NO / YES, How often? _____

m. **Relieving factors:** Nothing / fresh air / nebulizers / nitroglycerin / rest / oxygen / sitting / inhalers / medications oral prednisone / Other: _____

n. **Aggravating factors:** Nothing / anxiety/ stress / normal activities / bending forward / mild activity(walking) moderate activity (climbing stairs) / strenuous activity(running) / laying flat/ upper extremity activity/ Other:_____

o. **Associated symptoms**: none / anxiety / chest pain / cough / fever / leg swelling / sputum wheezing / palpitations / lightheaded / other:_____

1. Do your legs swell? YES NO

a. Approximate Date of first episode: _____ Approximate Date of last episode: _____

b. **Frequency**(on average): _____ times per / week / month / year

c. **Duration:**(on average) _____ hours / days / weeks / months

d. **Severity:** Minimal / mild / mild to moderate / moderate / moderate to severe / severe

e. **What is the location of the swelling**: Foot / ankle / calf / knee / thigh / other:_____

f. **Context(when do your legs swell?):** Nothing / laying flat / sitting / standing / walking / other:_____

g. **What relieves the swelling**: Nothing compression stockings / leg elevation / lying flat / sitting / walking

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Patient Name: _____ DOB: _____DATE: _____

h. **Associated symptoms**: None / unusual weight gain / skin discoloration / ulcers / shortness of breath

4. Do you experience any palpitations (rapid heart beat or skipped beats)? YES NO

a. **Quality:** rare skipped beats / occasional skipped beats / frequent skipped beats / flutter sustained / regular / irregular / rapid heartbeat / other: _____

b. **Approximate Date of first episode:** _____ **Approximate Date of last episode:** _____

c. **Frequency of palpitations**(on average):_____ times per day / week / month / year

d. **Frequency Status:** more frequent / less frequent / no change/stable

e. **Duration (per episode)**: _____ seconds / minutes / hours / days

f. **Duration status:** longer / shorter / no change

g. **Severity**: Minimal / mild / mild-to-moderate / moderate / moderate-to-severe / severe

h. **Severity status:** increasing / decreasing / no change/stable

i. **Context:** None / sleep / rest / exertion(type?)_____ / other:_____

j. **Aggravating factors:** None / anxiety / stress / caffeine / alcohol / Sudafed / other-medications(type?)_____ / Other: _____

k. **Relieving factors**: None / cough / neck massage / bearing-down / cold water to face Exertion (type?) _____ / medications (type?)_____ / other:_____

l. **Associated symptoms:** None / shortness of breath / chest pain / dizziness / lightheadedness near-fainting / fainting / other:_____

5a. Have you ever fainted (with loss of consciousness)? YES NO

5b. Have you ever felt dizzy or like you were going to faint or pass out YES NO

a. **Quality** (circle all that apply): floating / imbalance / lightheadedness / spinning unstable horizon / loss of consciousness(fainted)

b. **Approximate Date of first episode:** _____ **Approximate Date of last episode:** _____

c. **Frequency**: _____ times per day / week / month / year

d. **Frequency status:** more frequent / less frequent / no change/stable

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Patient Name: _____ DOB: _____DATE: _____

e. **Duration** (on average): _____seconds / minutes / hours / days

f. **Context:** no warning / sitting to standing / abdominal pain/cramping / coughing / chest pain / other pain / nausea / palpitations / shortness of breath / ringing in ears / urination / bowel movement blood draw / fasting / vertigo / other:_____

g. **Aggravating factors**: none / dehydration / change of position(type?)_____ / head turning exercise(type?)_____ / medications (type?)_____ other:_____

h. **Relieving factors**: none / lying down / sitting / rest / medications (type?)_____ Other:_____

i. **Associated symptoms**: none / confusion / seizure / seizure-like activity / headache slurred speech / visual changes / weakness / chest pain / palpitations / shortness of breath / other:_____

6. Any other reason why you need to see a cardiologist?

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

Patient Signature _____

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