



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

Primary Care Physician: _____ Phone: _____

City / State: _____

Other Physicians: _____

What physician requested this consultation? _____

Requesting Physician Phone: _____ City: _____

Pharmacy: _____

Pharmacy City: _____ Pharmacy Phone: _____

Pharmacy Address or Intersection: _____

CHIEF COMPLAINT

What problems are you here for today? _____

CORONARY RISK FACTORS

Yes No Hypertension (high blood pressure) _____

Yes No Diabetes Mellitus _____

Yes No Abnormal Cholesterol / Triglycerides _____

Yes No Currently Smoking? _____

Yes No History coronary disease in immediate family? _____

Yes No Peripheral artery disease? (legs, carotids) _____

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

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
<input type="checkbox"/> Yes <input type="checkbox"/> No Echo (Cardiac Ultrasound)	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Stress Test	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Holter/Event Monitor	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Carotid Artery Ultrasound	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Catheterization	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Angioplasty/Stent Placement	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral Artery Angiogram (Non Heart)	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral Artery Angioplasty (Non Heart)	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Electrophysiology Study	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Rhythm Ablation	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker/ICD(defibrillator)	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> 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:

- | | |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema / COPD _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Apnea _____ |

GASTROINTESTINAL:

- | | |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Reflux(GERD) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Hiatal Hernia _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diverticulosis / Diverticulitis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease / Hepatitis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Gastritis _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Disease / Gallstones _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal Bleed _____ |

RENAL / GENITOURINARY:

- | | |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Stones _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease / Elevated Creatinine _____ |

NEUROLOGICAL / PSYCHOLOGICAL:

- | | |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Intracranial (in the brain) Bleeding _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure Disorder _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Dementia _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety Disorder _____ |

FEMALE REPRODUCTIVE: Not Applicable

- | | |
|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple miscarriages _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently Pregnant (number of weeks?) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Menopause (at what age?) _____ | |

Reviewed By: _____



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 Do Not Resuscitate 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
<input type="checkbox"/> Cigarettes	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> Cigars	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> Pipes	_____ per day	Years Smoked? _____ Quit Date? _____
<input type="checkbox"/> 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:
<input type="checkbox"/> Beer	_____ cans per day / wk / mo / yr
<input type="checkbox"/> Wine	_____ glasses per day / wk / mo / yr
<input type="checkbox"/> Spirits	_____ glasses per day / wk / mo / yr

Do you use caffeine? Yes Formerly Never

Type:	How much:	Quit (when)
<input type="checkbox"/> Caffeinated Coffee?	_____ cups per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Caffeinated Tea?	_____ cups per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Caffeinated Soda?	_____ cans per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____
<input type="checkbox"/> Chocolate?	_____ servings per day / wk / mo / yr	<input type="checkbox"/> Quit (when) _____

Reviewed By: _____



New Patient Medical Questionnaire

Patient Name: _____ DOB: _____ DATE: _____

Exercise?

No/Sedentary Occasional Regular Active Lifestyle Physically Unable to exercise

Type:	How much:	Check any applicable:
<input type="checkbox"/> Aerobics	How long? (Mins.) _____ How often? (Per wk) _____	<input type="checkbox"/> Started Exercising
<input type="checkbox"/> Cycling	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Dancing	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Jogging	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Running	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Swimming	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Team sports _____	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Walking	How long? (Mins.) _____ How often? (Per wk) _____	
<input type="checkbox"/> Weights	How long? (Mins.) _____ How often? (Per wk) _____	

Please choose the type of diet you are currently on?

Type:	How well do you follow:			
<input type="checkbox"/> Regular	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low fat/Chol	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low salt	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Renal	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> No Added Salt	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Low Carb	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Non-compliant with diet
<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Strictly	<input type="checkbox"/> Usually	<input type="checkbox"/> Occasionally	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>
Significant weight gain	<input type="checkbox"/>	<input type="checkbox"/>

CARDIAC:

	YES	NO
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest pressure	<input type="checkbox"/>	<input type="checkbox"/>

ENMT:

	YES	NO
Excessive Snoring	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing while laying flat	<input type="checkbox"/>	<input type="checkbox"/>
Awakening with breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY:

	YES	NO
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Swelling in feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL:

	YES	NO
Blood in stools (black stools)	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>

GENTOURINARY:

	YES	NO
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Nearly passing out spells	<input type="checkbox"/>	<input type="checkbox"/>
Passing out spells	<input type="checkbox"/>	<input type="checkbox"/>

VASCULAR:

	YES	NO
Calf pain with walking	<input type="checkbox"/>	<input type="checkbox"/>

Any other reason why you need to see a cardiologist?**MUSCULOSKELETAL:**

	YES	NO
Muscle pain at rest	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL:

	YES	NO
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC:

	YES	NO
Excessive stress	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE:

	YES	NO
Feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGICAL:

	YES	NO
Unusual bleeding	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

Reviewed By: _____



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

Reviewed By: _____ 15



New Patient Medical Questionnaire

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

Reviewed By: _____



New Patient Medical Questionnaire

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 _____

Reviewed By: _____