



New Patient Medical Questionnaire

DATE: _____

Patient Name: _____ DOB: _____ AGE: _____

Primary Care Physician: _____ City / State: _____

Other Physicians: _____

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:

- Cardiomegaly (Enlarged Heart)
Heart Disease you were born with(congenital)
Rheumatic Fever
Murmur
Abnormal Heart Valve
Endocarditis (infected heart valve)
Abnormal ECG
Angina (heart pain)
Heart Attack
Coronary Artery Disease
Heart Failure / Cardiomyopathy
Arrhythmia / Abnormal Rhythm
Previous Cardiac Arrest
Defibrillated / Shocked
Pericardial(sac surrounding heart) Disease
Marfan's Syndrome
Hospitalized for cardiac reasons
Other type of heart disease

VASCULAR:

- Carotid Artery Disease
Renal(kidney) Artery Disease
Peripheral(leg or arm) Artery Disease
Pulmonary embolism (clots in lung)
Varicose Veins
Stroke or TIA (mini-stroke)
Any history of aneurysm
DVT (clots in leg)
Other type of vascular Disease

CORONARY RISK FACTORS

- Hypertension (high blood pressure)
Abnormal Cholesterol / Triglycerides
History coronary disease in immediate family?
Diabetes Mellitus
Currently Smoking?
Peripheral artery disease? (legs, carotids)

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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.

Table with 3 columns: Procedure Name, Year, Location. Rows include Echo (Heart Ultrasound), Stress Test, Holter/Event Monitor, Carotid Artery Ultrasound, Heart Catheterization, Heart Angioplasty/Stent Placement, Peripheral Artery Angiogram (Non Heart), Peripheral Artery Angioplasty (Non Heart), Electrophysiology Study, Heart Rhythm Ablation, Pacemaker/ICD(defibrillator), 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:

- Asthma, Emphysema / COPD, Pneumonia, Bronchitis, Tuberculosis, Sleep Apnea

GASTROINTESTINAL:

- Reflux(GERD), Diverticulosis / Diverticulitis, Liver Disease / Hepatitis, Gallbladder Disease / Gallstones, Hiatal Hernia, Ulcers, Gastritis, Gastrointestinal Bleed

RENAL / GENITOURINARY:

- Dialysis, Kidney Stones, Prostate Disease, Kidney Disease / Elevated Creatinine

NEUROLOGICAL / PSYCHOLOGICAL:

- Intracranial (in the brain) Bleeding, Migraine Headaches, Depression, Seizure Disorder, Dementia, Anxiety Disorder

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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
<i>Example: Gallbladder Removed</i>	<i>1980</i>	<i>Dr. Frank Smith</i>	<i>Parkland, Dallas</i>

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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

<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) _____

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Do you use recreational drugs? **Yes** **Formerly** **Never**

Type:	How much:	Start/Quit Dates
<input type="checkbox"/> Marijuana	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Cocaine	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Methamphetamine	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____
<input type="checkbox"/> Other	_____ per day/wk/mo/yr	When did you start? _____ Quit? _____ Rehab? _____

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"/> 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

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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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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:

Significant weight loss YES NO
Significant weight gain YES NO

CARDIAC:

Chest pain YES NO
Chest pressure YES NO

ENMT:

Excessive Snoring YES NO

Shortness of breath YES NO
Difficulty breathing while laying flat YES NO
Awakening with breathing difficulty YES NO

RESPIRATORY:

Coughing up blood YES NO

Swelling in feet/ankles YES NO

GASTROINTESTINAL:

Blood in stools (black stools) YES NO

Palpitations YES NO

GENITOURINARY:

Blood in urine YES NO

Nearly passing out spells YES NO
Passing out spells YES NO

VASCULAR:

Calf pain with walking YES NO

Any other reason why you need to see a cardiologist?

MUSCULOSKELETAL:

Muscle pain at rest YES NO

NEUROLOGICAL:

Dizziness YES NO

PSYCHIATRIC:

Excessive stress YES NO

ENDOCRINE:

Feel cooler than others YES NO

HEMATOLOGICAL:

Unusual bleeding YES NO

Thank you for taking the time to complete this questionnaire.

Patient Signature _____

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