Waco Heart & Vascular

New Patient Medical Questionnaire

Patient Name: _____ DOB: _____AGE: _____
Primary Care Physician: _____
City / State: _____
What physician requested this consultation? _____
How did you hear about us? Referral Radio TV Family/Friend News Paper Magazine
Other_____

CHIEF COMPLAINT

What problems are you here for today?

_____

_____

Circle any of the following disorders that you HAVE or HAVE HAD, and the year it was first identified.

CARDIAC:

Chest pain/Chest pressure?
Shortness of breath?
Difficulty breathing while lying flat?
Swelling in feet/ankles?
Palpitations?
Nearly passing out spells? Passing out spells?
Coronary Artery Disease?
Heart Disease you were born with (congenital)**?**
Rheumatic Fever**?**
Previous Cardiac Arrest?
Pericardial (sac surrounding heart) Disease**?**
Endocarditis (infected heart valve)?
Cardiomegaly (Enlarged Heart)**?**
Awakening with breathing difficulty?
Abnormal ECG?
Abnormal ECG?
Heart Attack?
Arrhythmia / Abnormal Rhythm?
Heart Failure / Cardiomyopathy**?**
Murmur**?**
Abnormal Heart Valve**?**
Marfan's Syndrome

VASCULAR:

Carotid Artery Disease (arteries in your neck) **Yes No?**
Renal (kidney) Artery Disease **Yes No?**
Peripheral (leg or arm) Artery Disease **Yes No?**
DVT (clots in leg) **Yes No?**
Pulmonary embolism (clots in lung) **Yes No?**
Varicose Veins **Yes No?**
Stroke or TIA (mini-stroke) **Yes No?**
Pain in the Legs?

CORONARY RISK FACTORS

Hypertension (high blood pressure)? **Yes No**
Abnormal Cholesterol / Triglycerides**? Yes No**
History coronary disease in immediate family**? Yes No**
Diabetes Mellitus**? Yes No**

CARDIAC PROCEDURES/DIAGNOSTIC TESTING

Please circle if you have had or have not had any of these procedures / diagnostic tests.
Echo (Heart Ultrasound)**? Yes No**
Stress Test**? Yes No**
Holter/Event Monitor? **Yes No**
Carotid Artery Ultrasound Yes No Heart Catheterization/Angioplasty/Stent Placement? **Yes No**
Peripheral Artery Angiogram (Non Heart)**? Yes No**
Electrophysiology Study/Ablation**? Yes No**
Pacemaker/ICD (defibrillator)**? Yes No**

Cardiac Surgery**? Yes No**

PAST MEDICAL HISTORY: Please circle any of the following disorders that you HAVE or HAD

PULMONARY:

Asthma? **Yes No**
Bronchitis? **Yes No**
Emphysema? **Yes No**
COPD? **Yes No**
Tuberculosis? **Yes No**
Pneumonia? **Yes No**
Sleep Apnea**? Yes No** if yes do you use a C-Pap Machine**? Yes No**

GASTROINTESTINAL:

Reflux (GERD? **Yes No**)
Hernia**? Yes No**
Diverticulosis / Diverticulitis**? Yes No**
Ulcers**? Yes No**
Liver Disease / Hepatitis**? Yes No**
Gallbladder Disease / Gallstones Gastrointestinal Bleed**? Yes No**

RENAL / GENITOURINARY:

Dialysis**? Yes No**
Kidney Stones**? Yes No**
Kidney Disease / Elevated Creatinine**? Yes No**
Prostate Disease**? Yes No**

NEUROLOGICAL / PSYCHOLOGICAL:

Intracranial (in the brain) Bleeding**? Yes No**
Seizure Disorder**? Yes No**
Migraine Headaches**? Yes No**
Dementia**? Yes No**
Depression**? Yes No**
Anxiety Disorder**? Yes No**

FEMALE REPRODUCTIVE:

Currently Pregnant? **Yes No**

ENDOCRINE:

Thyroid Disorder? **Yes No**
Adrenal Disorder? **Yes No**

OTHER:

Cancer (type?)
Autoimmune Disorders (i.e. Lupus)

Please list any other health problems that are not on the list:

_____
_____
_____
_____

SOCIAL HISTORY

Marital Status? Single Married Divorced Separated Widowed Domestic Partner
Number of sons? _____Number of daughters? _____ With whom do you live? _____
Do you have a Medical Power of Attorney? **Yes No** Who? _____
Advanced Directives? Yes No
Do **N**ot **R**esuscitate? _____
Living Will? _____
Are you retired? Yes No Current or Previous Occupation: _____
Primary language? _____
Leisure activities? (Include any hobbies) _____
Home blood pressure monitor? Yes / No If yes, average readings: _____

Do you use tobacco? Yes Formerly Never
Type: Cigarettes, Cigars, Pipes, Chewing tobacco _____per da. Years Used? _____Quit Date?

Do you use alcohol? Yes Formerly Never
Describe your use? Rarely Social Daily Frequently Occasional Quit (when?)
Beer / Wine / Spirits ____ cans 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) _____

Do you use recreational drugs? Yes, Formerly, Never
Type: Marijuana**,** Cocaine**,** Methamphetamine**,** Other
How much: per day/wk/mo/yr **Start/Quit Dates** When did your start? _____ Quit? _____ Rehab? _____

Exercise? Check any if applicable:
No/Sedentary Occasional Regular Active Lifestyle Physically Unable to exercise
Type: Aerobics**,** Cycling**,** Dancing**,** Jogging**,** Running**,** Swimming, Walking, Weights
How long? (Mins.) _____How often? (Per wk) _____

Please choose the type of diet you are currently on?
How well do you follow: Strictly Usually Occasionally Non –compliant with diet
Type: Regular**,** Low fat/Chol, Low salt**,** Diabetic**,** Renal**,** No Added Salt**,** Weight Loss**,** Low Carb**,** Vegetarian

FAMILY HISTORY Adopted?
Please indicate below if your FATHER, MOTHER, SIBILING(S), or CHILDREN have ever been diagnosed with any of the following conditions:
Heart Attack
Heart Surgery
Heart Disease
Sudden/Unexpected Death
Stroke/TIA (mini stroke)
Hypertension
Hyperlipidemia
Diabetes
Other
_____
_____
_____

CURRENT MEDICATIONS / SUPPLEMENTS

Please list ALL the medications that you are taking 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) _____ _____ _____

SURGICAL HISTORY / OPERATIONS Yes / None

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

_____
_____
_____
_____
_____

ALLERGIES / INTOLERANCES TO MEDICATIONS

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)

_____ _____
_____ _____
_____ _____

LAB WORK: Month & Year of most recent? _____
Location? _____

Please list any other physicians that monitors your care:

_____
_____
_____

Thank you for taking the time to complete this questionnaire
Any other reason why you need to see a cardiologist?

_____
_____
_____

Patient Signature _____