HealthPoint
Medical Group

New Patient Health Questionnaire

Cardiovascular Supplement

Name: _____ Date: _____

DOB: _____ Age: _____ New Patient____ Established ____

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

Past Medical History: Please indicate if you have had any of the following illnesses or procedures by checking Yes or No to each one.

Yes **No**

___ ___ **Congenital** (born with it) **heart problem.** If so, age at diagnosis:_____ years old
Describe congenital heart problem: _____
_____

___ ___ **Ischemic Heart Disease** (heart blockages, angina or heart attack)

___ ___ **Heart Attack** (coronary occlusion, myocardial infarction):
If yes, indicate date of first heart attack: _____/_____
Where (what hospital) were you treated?
Name of hospital: _____
City/State: _____ / _____
Indicate date(s) of other heart attacks (month and year of each):
_____

___ ___ **Heart Catheterization** (heart cath, dye test to arteries in heart, dye test to heart, measurement of pressure in the heart, angioplasty, stent).

___ ___ **Heart failure** (Congestive Heart Failure, Fluid in the Lungs, Fluid in the Heart)
If yes: Date of diagnosis (when were you told of disease, month/year): _____/_____
Have you been in the hospital for Heart Failure in the Past? ☐Y ☐N

___ ___ **Heart rhythm problems** (abnormal rhythms, skipped beats, heart too fast or slow)
If yes (use reverse of page if needed for more details)
Type: ☐ Atrial flutter/fibrillation
☐ Ventricular tachycardia/fibrillation ("V-Tach")
☐ Heart block (bradycardia, too slow)
Heart rhythm devices: **(Please bring your pacemaker card with you to clinic)**
☐ Pacemaker
☐ Defibrillator

___ ___ **Stroke** (CVA, Cerebrovascular Accident, "Brain Attack", Blood Clot to Brain):
If yes: Date of first _____/_____; Date of last _____/_____
If yes: Do you have any weakness, speech or other problem as a result of the stroke?
If yes, please describe:_____

___ ___ **High Blood Pressure**

___ ___ **High Cholesterol or Fat in Blood**

___ ___ **Cancer** If yes (please use reverse for details if you had more than one cancer):
What type?_____ Location in Body:_____
When Diagnosed: Month/Year _____/_____

Yes **No**

___ ___ **Sleep Apnea / Sleep Disorder**
___ ___ **Asthma**
___ ___ **Emphysema/COPD**
___ ___ **Diabetes** (high sugar)
___ ___ **Thyroid Disease** (check all that apply)

Type: ☐ Hyper (elevated, high)
☐ Hypo (low)
☐ Goiter (enlarged)

___ ___ **Kidney (renal) Disease**
___ ___ **Kidney or Bladder Stones**
___ ___ **Ulcer in Stomach**
___ ___ **Bleeding Ulcer or Bowe**l
___ ___ **Hiatal Hernia**
___ ___ **Heartburn or Reflux**
___ ___ **Diverticulitis**
___ ___ **Bleeding Bowel**
___ ___ **Hepatitis** (jaundice)
___ ___ **Pancreatitis**
___ ___ **Gallbladder Stones/infection**
___ ___ **Clot in Leg Veins**
___ ___ **Clot to Lung**
___ ___ **Clot to Artery in Arm or Leg**
___ ___ **Gout, High Uric or Leg**
___ ___ **Arthritis**

If so, type of arthritis:_____

Family History of Medical Problems (Please complete the following chart about your family members)

Family Member (For siblings, √ box to show if brother or sister)	**Alive?** (√ yes or no. If no, list cause of death)	**Age** (Now or at death)	**For each family member, please show any history of the following illnesses by checking (√) the applicable boxes below.** (If you have more than 2 brothers or sisters, please write their information on the back of this page.)	
Mother	☐**Yes** ☐**No** Cause of death:	_____ **yrs.**	☐ **Heart Attack** (age at 1st___) ☐ **Heart Artery Blockage** ☐ **Heart Stent** ☐ **Heart Bypass Surgery** ☐ **Heart Valve Surgery** ☐ **Heart Failure** ☐ **Congenital** (born with) Heart Problem	☐ **Diabetes** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Stroke** (age at 1st___) ☐ **Cancer** (If yes, write type and location): _____ ☐ **Other:** _____
Father	☐**Yes** ☐**No** Cause of death:	_____ **yrs.**	☐ **Heart Attack** (age at 1st___) ☐ **Heart Artery Blockage** ☐ **Heart Stent** ☐ **Heart Bypass Surgery** ☐ **Heart Valve Surgery** ☐ **Heart Failure** ☐ **Congenital** (born with) Heart Problem	☐ **Diabetes** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Stroke** (age at 1st___) ☐ **Cancer** (If yes, write type and location): _____ ☐ **Other:** _____
☐ **Brother** ☐ **Sister**	☐**Yes** ☐**No** Cause of death:	_____ **yrs.**	☐ **Heart Attack** (age at 1st___) ☐ **Heart Artery Blockage** ☐ **Heart Stent** ☐ **Heart Bypass Surgery** ☐ **Heart Valve Surgery** ☐ **Heart Failure** ☐ **Congenital** (born with) Heart Problem	☐ **Diabetes** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Stroke** (age at 1st___) ☐ **Cancer** (If yes, write type and location): _____ ☐ **Other:** _____
☐ **Brother** ☐ **Sister**	☐**Yes** ☐**No** Cause of death:	_____ **yrs.**	☐ **Heart Attack** (age at 1st___) ☐ **Heart Artery Blockage** ☐ **Heart Stent** ☐ **Heart Bypass Surgery** ☐ **Heart Valve Surgery** ☐ **Heart Failure** ☐ **Congenital** (born with) Heart Problem	☐ **Diabetes** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Stroke** (age at 1st___) ☐ **Cancer** (If yes, write type and location): _____ ☐ **Other:** _____

Physician Signature:_____ Date:_____