



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:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiomegaly (Enlarged Heart) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Artery Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease you were born with(congenital)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Failure / Cardiomyopathy _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arrhythmia / Abnormal Rhythm_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Murmur _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous Cardiac Arrest _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Heart Valve _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Defibrillated / Shocked _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocarditis (infected heart valve)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pericardial(sac surrounding heart) Disease_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal ECG_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Marfan's Syndrome_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina (heart pain)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalized for cardiac reasons_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other type of heart disease _____ |

VASCULAR:

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Carotid Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke or TIA (mini-stroke)_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal(kidney) Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any history of aneurysm _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral(leg or arm) Artery Disease _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | DVT (clots in leg) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pulmonary embolism (clots in lung) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other type of vascular Disease _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins _____ | | |

CORONARY RISK FACTORS

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension (high blood pressure) _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Mellitus _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Cholesterol / Triglycerides _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently Smoking? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | History coronary disease in immediate family? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | 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.

	Year	Location
<input type="checkbox"/> Yes <input type="checkbox"/> No Echo (Heart 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	_____	_____

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:

- | | |
|---|---|
| <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 _____ |

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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

Table with 3 columns: Type, How much, Start/Quit Dates. Rows include Cigarettes, Cigars, Pipes, and Chewing tobacco.

Do you use alcohol? Yes Formerly Never

Describe your use?

Rarely Social Daily Frequently Occasional Quit (when)

Table with 2 columns: Type, How much. Rows include Beer, Wine, and Spirits.

Do you use caffeine? Yes Formerly Never

Table with 2 columns: Type, How much. Rows include Caffeinated Coffee, Caffeinated Tea, Caffeinated Soda, and Chocolate.

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Do you use recreational drugs? Yes Formerly Never

Table with 3 columns: Type, How much, Start/Quit Dates. Rows include Marijuana, Cocaine, Methamphetamine, and Other.

Exercise?

No/Sedentary Occasional Regular Active Lifestyle Physically Unable to exercise

Table with 3 columns: Type, How much, Check any applicable. Rows include Aerobics, Cycling, Dancing, Jogging, Running, Swimming, Team sports, Walking, and Weights.

Please choose the type of diet you are currently on?

Table with 2 columns: Type, How well do you follow. Rows include Regular, Low fat/Chol, Low salt, Diabetic, Renal, No Added Salt, Weight Loss, Low Carb, and Vegetarian.

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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 _____

Reviewed By: _____