Center for Diagnostic & Therapeutic Cardiology

Patient Questionnaire

MR# _____ Patient Name _____ Date _____

Birthday _____ Age _____ Primary Care MD or Referring MD _____

Pharmacy/Address/City/State/Zip _____ Phone # _____

Reason for today's visit _____ Recent Testing (radiology, procedure, lab work?) ☐ **Yes** ☐ **No**

What? _____ Where? _____

Any new medical problems or surgeries since your last visit? _____

Have you been discharge from an inpatient facility in the past 30 days? ☐ Yes ☐ No **When?** _____

Medical History:

Are you currently experiencing any of the following symptoms? (check Yes or No)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	chest pain	☐	☐	chills	☐	☐	blood in urine	☐	☐	excessive snoring
☐	☐	shortness of breath	☐	☐	fever	☐	☐	blood in stool	☐	☐	cold or heat intolerance
☐	☐	fatigue	☐	☐	weight gain	☐	☐	abdominal pain	☐	☐	excessive thirst/urination
☐	☐	muscle weakness/pain	☐	☐	weight loss	☐	☐	indigestion	☐	☐	vision changes
☐	☐	exercise intolerance	☐	☐	swelling	☐	☐	nausea	☐	☐	ringing in ears
☐	☐	dizziness	☐	☐	easy bruising	☐	☐	vomiting	☐	☐	vertigo
☐	☐	passing out	☐	☐	nose bleeds	☐	☐	cough	☐	☐	seizures
☐	☐	palpitations	☐	☐	vomiting blood	☐	☐	wheezing	☐	☐	male impotence
☐	☐	pain in legs/buttocks at rest	☐	☐	pain in legs/buttocks when walking						

Are you allergic to any medications? ☐ Yes ☐ No (list) _____

Are you allergic to IV Dye/Contrast? ☐ Yes ☐ No **Are you allergic to Shellfish?** ☐ Yes ☐ No

Have you been treated for any of the following conditions? (Check Yes or No)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	high blood pressure	☐	☐	high cholesterol	☐	☐	kidney problems	☐	☐	tuberculosis (TB)
☐	☐	heart failure	☐	☐	blood clots	☐	☐	rheumatic fever	☐	☐	cancer
☐	☐	blockage of the heart	☐	☐	stroke	☐	☐	hiatal hernia	☐	☐	sleep apnea
☐	☐	blockage of the neck/leg	☐	☐	diabetes	☐	☐	stomach problems	Other _____		
☐	☐	abnormal heart rhythm	☐	☐	lung disease	☐	☐	thyroid problems			

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled **Occupation:** _____

Exercise? ☐ Yes ☐ No **What do you do and how often?** _____

Caffeine? ☐ Yes ☐ No **What and how much?** _____ **Alcohol?** ☐ Yes ☐ No **What and how much?** _____

Recreational Drugs? ☐ Yes ☐ No **What and how much?** _____

Preventive Care History:

Do you smoke or use tobacco products? ☐ Yes ☐ No **How many packs per day?** _ **How long?**___ **Interested in Quitting?** ☐ Yes ☐ No

Smoking Cessation Education Offered ☐ Yes ☐ No **Do you have an Advanced Plan of Care/Directive?** ☐ Yes ☐ No

Have you provided a copy to the office? ☐ Yes ☐ No **Would you like information regarding Advanced Care Planning?** ☐ Yes ☐ No

Have you received the annual flu vaccination? ☐ Yes ☐ No **Pneumonia vaccination within the last 5 yrs?** ☐ Yes ☐ No

Are you currently taking an Aspirin or other antiplatelet daily? ☐ Yes ☐ No **If other, what?** _____

Are you currently taking Warfarin or other anticoagulant? ☐ Yes ☐ No **If other, what?** _____

Family History: (Are there members of your immediate family with the following conditions or history?)

Heart Disease? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Heart surgery? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Irregular heart rhythms? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

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DATE	NO CHANGES	DESCRIPTON OF CHANGES FROM PREVIOUS QUESTIONNAIRE	PHYSICIAN SIGNATURE

Physician Signature _____