

# HEALTH QUESTIONNAIRE



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

What is the reason for your visit to the cardiologist?

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Please answer the following and explain all "Yes" answers.

Have you had or do you have

<input type="checkbox"/> Yes	<input type="checkbox"/> No	A heart attack ?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Angina ?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain or pressure?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath - Please mark one if yes, <input type="checkbox"/> activity <input type="checkbox"/> rest <input type="checkbox"/> lying down
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Palpitations, fast or slow heart rates?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Passing out or near fainting or dizziness?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Congestive heart failure or enlarged heart?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of your legs?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blue lips or fingernails?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leg pain or cramps with walking?

**Risk Factors**

Do you have any of the following

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High cholesterol
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you or did you smoke? If yes, how many packs a day _____ for how many years _____
		When did you quit _____

Please list any past medical problems


Please list any surgeries that you have had

Date:	Type of surgery

Date:	Type of surgery

Please list any serious illness or hospitalizations

Date:	Type of illness

Date:	Type of illness

**Social History**

Your occupation? \_\_\_\_\_

Marital Status? \_\_\_\_\_ Do you have any Children? \_\_\_\_\_ How Many? \_\_\_\_\_

Exercise	<input type="checkbox"/> Sedentary ( No exercise)			
	<input type="checkbox"/> Mild exercise			
	<input type="checkbox"/> Occasional vigorous exercise			
	<input type="checkbox"/> Regular vigorous exercise			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	<input type="checkbox"/> Coffee
	# of cups / cans per day?			
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?			
Drugs	Do you currently use recreational / street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Family History of Heart disease /stroke / sudden death**

	Age	Significant health problems
Father		
Mother		
Siblings	<input type="checkbox"/> F <input type="checkbox"/> M	
	<input type="checkbox"/> F <input type="checkbox"/> M	
	<input type="checkbox"/> F <input type="checkbox"/> M	
Other		

**Review of Systems** Check if you have, or have had, any symptoms in the following areas to a significant degree.

<input type="checkbox"/> Recent weight loss or gain	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Kidney Failure
<input type="checkbox"/> Recent fever or chills	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Seizure or convulsion	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Asthma or lung problems	<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Diarrhea /constipation	<input type="checkbox"/> Snoring or apnea	<input type="checkbox"/> Anemia
<input type="checkbox"/> Weakness in arms or legs	<input type="checkbox"/> Stomach/peptic ulcers /bleeding	<input type="checkbox"/> Cancer
<input type="checkbox"/> Loss of Vision/double vision	<input type="checkbox"/> A history of/or hiatal hernia	<input type="checkbox"/> Easy bleeding or bruising
<input type="checkbox"/> Difficulty with speech	<input type="checkbox"/> Blood in stools or dark and tarry	<input type="checkbox"/> Blood Clots in legs/lungs
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Diarrhea or constipation	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Difficulty swallowing food	<input type="checkbox"/> Hepatitis or cirrhosis of the liver	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Thyroid abnormality	<input type="checkbox"/> Problems with liver	<input type="checkbox"/> Depression
<input type="checkbox"/> Carotid artery blockage/surgery	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of sexual function

Reviewed by: \_\_\_\_\_

\_\_\_\_\_  
Cardiologist

\_\_\_\_\_  
Date:







