Cardiovascular Consultants, P.C.

Diagnostic and Interventional Cardiology

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

RISK FACTORS

Diabetes	☐ No	☐ Yes	**WOMEN ONLY:**			
High blood pressure	☐ No	☐ Yes				
High cholesterol	☐ No	☐ Yes	History of Preeclampsia	☐ No	☐ Yes	
Smoking	☐ No	☐ Yes	History of Toxemia of pregnancy	☐ No	☐ Yes	
Family history of heart disease	☐ No	☐ Yes	History of Gestational Diabetes	☐ No	☐ Yes	
Are you overweight?	☐ No	☐ Yes	History of miscarriage 2nd trimester	☐ No	☐ Yes	
Are you involved in regular exercise program?	☐ No	☐ Yes				

PAST MEDICAL HISTORY

Heart attack	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes
Heart failure	☐ No	☐ Yes
Hereditary heart defects	☐ No	☐ Yes
Blood clots in the lung	☐ No	☐ Yes
Blood clots in the legs	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Thyroid disease	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Stroke	☐ No	☐ Yes

PREVIOUS SURGERIES / PROCEDURES

Coronary bypass surgery	☐ No	☐ Yes, date:_____	Hospital: _____
Cardiac catheterization	☐ No	☐ Yes, date: _____	Hospital: _____
Angioplasty / Stent	☐ No	☐ Yes, date: _____	Hospital: _____
Pacemaker / Defibrillator	☐ No	☐ Yes, date: _____	Hospital: _____
Other surgery (s)	☐ No	☐ Yes, date and type of surgery:	

_____

_____

MEDICATIONS (Please list all medications you are currently taking)

Medicaton	size/mg	per day	Medication	size/mg	per day
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

ALLERGIES (Please list any allergies you may have)

_____

_____

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SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of children_____
Use of alcohol: ☐ Never ☐ Rarely ☐ Daily
Use of tobacco: ☐ Never ☐ Previously, but quit (year) _____ ☐ Current packs/day_____
Use of "recreational drugs": ☐ Never ☐ Yes

FAMILY MEDICAL HISTORY

Does anyone in your family have or had heart disease, stroke, heart attack, high cholesterol, high blood pressure, diabetes, sudden death, heart failure?

	Age	Disease(s)	Alive	Dead	If deceased, cause of death
Father	_____	_____	☐	☐	_____
Mother	_____	_____	☐	☐	_____
Siblings (list each)					
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____
	_____	_____	☐	☐	_____

REVIEW OF SYSTEMS

CARDIOVASCULAR **PHYSICIAN COMMENTS**

Chest pain / angina ☐ No ☐ Yes
Palpitations ☐ No ☐ Yes
Shortness of breath with walking or lying ☐ No ☐ Yes
Swelling feet, ankles, or hands ☐ No ☐ Yes
Wake up during night with difficulty breathing ☐ No ☐ Yes

_____

RESPIRATORY

Chronic or frequent coughs ☐ No ☐ Yes
Spitting up blood ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Asthma / wheezing ☐ No ☐ Yes

_____

VASCULAR / MUSCULOSKELETAL

Swollen legs, feet, ankles ☐ No ☐ Yes
Leg pain, walking or resting ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes
Joint pain ☐ No ☐ Yes
Cold extremeties ☐ No ☐ Yes

_____

CONSTITUTIONAL SYMPTOMS

Good general health lately ☐ No ☐ Yes
Recent weight change ☐ No ☐ Yes
Fever / chills ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes
Headaches ☐ No ☐ Yes

_____

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EYES			**PHYSICIAN COMMENTS**
Wear glasses / contacts	☐ No	☐ Yes	
Blurred / double vision	☐ No	☐ Yes	

EARS / NOSE / MOUTH / THROAT		
Ringing in ears	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Sore throat / voice changes	☐ No	☐ Yes
Swollen glands	☐ No	☐ Yes

GASTROINTESTINAL		
Loss of apetite	☐ No	☐ Yes
Rectal bleeding / blood in stool	☐ No	☐ Yes
Abdominal pain or heartburn	☐ No	☐ Yes
Peptic ulcers	☐ No	☐ Yes
Gall stones	☐ No	☐ Yes

GENITOURINARY		
Problems urinating	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes

NEUROLOGICAL		
Stroke	☐ No	☐ Yes
Blackouts	☐ No	☐ Yes
Numbness / tingling	☐ No	☐ Yes
Convulsions / seizures	☐ No	☐ Yes

HEMATOLOGICAL / LYMPHATIC		
Anemia	☐ No	☐ Yes
Easy bruising	☐ No	☐ Yes

SKIN		
Skin rash, swelling, itching	☐ No	☐ Yes

ENODCRINE		
Glandular / hormone problems	☐ No	☐ Yes
Excessive thirst / urination	☐ No	☐ Yes
Heat / cold intolerance	☐ No	☐ Yes

PSYCHIATRIC		
Memory loss or confusion	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

MD Signature _____ Date _____