

# CARDIAC SOLUTIONS

## PATIENT QUESTIONNAIRE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Who referred you to Cardiac Solutions: \_\_\_\_\_

What is your primary concern for which you have been referred? \_\_\_\_\_

I am allergic to the following medications: \_\_\_\_\_

I have had the following Operations: \_\_\_\_\_

I am currently taking these medications: \_\_\_\_\_

### FAMILY HISTORY

**MOTHER** Living: \_\_\_\_\_ Age \_\_\_\_\_ With Medical Problems: \_\_\_\_\_

Died: \_\_\_\_\_ Age \_\_\_\_\_ Of: \_\_\_\_\_

**FATHER** Living: \_\_\_\_\_ Age \_\_\_\_\_ With Medical Problems: \_\_\_\_\_

DIED: \_\_\_\_\_ AGE \_\_\_\_\_ Of: \_\_\_\_\_

**BROTHERS** Of These, \_\_\_\_\_ Brother/s Have Died of: \_\_\_\_\_

Of These, \_\_\_\_\_ Brother/s still living have health problems: \_\_\_\_\_

**SISTERS #** Of These, \_\_\_\_\_ Sister/s have died of: \_\_\_\_\_

Of These, \_\_\_\_\_ Sister/s still living have health problems: \_\_\_\_\_

Are there any other diseases that tend to occur frequently in your family? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain. \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_

When was your last electrocardiogram (EKG) ? \_\_\_\_\_

## HABITS

I Smoke Now: Yes \_\_\_ No \_\_\_ I quit in \_\_\_\_\_ If yes or I quit, please answer the following:

Packs Per Day \_\_\_\_\_ Number of years \_\_\_\_\_ What: Cigarettes Cigars Other (circle)

I Drink Alcohol: Yes \_\_\_ No \_\_\_ I quit in \_\_\_\_\_ If yes or I quit, please answer the following:

How often: Rarely \_\_\_\_\_ Almost Every Day \_\_\_\_\_ Daily \_\_\_\_\_. Amount \_\_\_\_\_

Favorite Beverage: Wine \_\_\_\_\_ Beer \_\_\_\_\_ Liquor \_\_\_\_\_ Other \_\_\_\_\_

How many cups of the following are consumed per day: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soft Drinks \_\_\_\_\_

Prior use of Cocaine or Amphetamines: Yes \_\_\_ No \_\_\_

## CARDIAC REVIEW

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

Angina	_____	Passing Out	_____
Chest Pain	_____	Dizziness	_____
Heart Attack	_____	Cramps in legs when walking	_____
Short of breath while walking	_____	Rheumatic Fever	_____
Swollen Ankles	_____	History of Heart Murmur	_____
Cough while lying down	_____	High Cholesterol	_____
Gasping for breath lying down	_____	Blue baby at birth	_____
Loss of Energy/Fatigue	_____	Palpitations/Fluttering in Chest	_____
Recent Flu-like Illness/Fever	_____	High Blood Pressure	_____

## PAST HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

Stroke	_____	Stomach, Colon or Liver Problems	_____
Diabetes	_____	Hiatal Hernia	_____
Glaucoma or other Eye problems	_____	Phlebitis	_____
Lung Disease	_____	Arthritis or Rheumatism	_____
Kidney or Bladder Problems	_____	Syphilis	_____
Prostate Problems	_____	Cancer	_____
Hepatitis, Jaundice, Pancreatitis	_____	Anemia, Bleeding, Easy bruising	_____

## MISCELLANEOUS NOTES

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