CARDIAC SOLUTIONS

PATIENT QUESTIONAIRE

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

_____

_____