CARDIAC MEDICAL HISTORY QUESTIONNAIRE

YOUR PERSONAL INFORMATION:

Today's Date: _____ (mm/dd/yyyy) Date of birth: _____ (mm/dd/yyyy)
Age: _____ Gender : Male ___ Female ___
Weight: _____ (pounds) Height: _____ feet ____ inches

NAME: _____

ADDRESS:
Street _____ Apt # _____
City _____ State _____ Zip code _____

HOME Phone Number with area code: _____
WORK Phone Number with area code: _____
CELL Phone Number with area code: _____
FAX Phone number with area code: _____
EMAIL ADDRESS: _____

PHYSICIAN INFORMATION: (If known)

Your Primary Care Doctor's:
Name: _____
Address:
Street _____ Suite # _____
City _____ State _____ Zip code _____ Telephone Number (___)_____

Your Cardiologist's:
Name: _____
Address:
Street _____ Suite # _____
City _____ State _____ Zip code _____Telephone Number (___)_____

IF YOU DO NOT UNDERSTAND A QUESTION, THEN IT PROBABLY MEANS THAT YOU DO NOT HAVE THE CONDITION

DO YOU HAVE KNOWN HEART DISEASE ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
Please check all spaces that apply to you

○ High blood pressure	○ Chest pain on exertion	○ Enlarged heart	○ Coronary artery disease
○ Previous heart attack Date:		○ Idiopathic cardiomyopathy	○ Hypertrophic cardiomyopathy
○ Valvular heart disease Date diagnosed:		○ Congestive heart failure	○ Pericarditis
○ Endocarditis	○ Congenital heart disease Type:	○ Previous heart surgery Type:	○ Tachcardia mediated cardiomyopathy

DO YOU HAVE DISEASE IN ARTERIES OTHER THAN THE HEART ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
Please check all spaces that apply to you.

○ Renal insufficiency	○ Peripheral vascular disease	○ Diabetes Year diagnosed	○ On Insulin
○ Previous DVT (Leg or arm clots)		○ Other_____	○

RISK FACTOR DETERMINATION (Please check all spaces that apply to you.)

○ Sedentary lifestyle	○ Currently smoking	○ Quit smoking	○ Lifetime non-smoker
○ Regular exerciser How much?	○ Relatives with heart attack ○ Immediate ○Paternal ○Maternal	○ Relatives with coronary artery disease ○Immediate ○Paternal ○Maternal	○ High cholesterol Value (if Known)
○ Overweight	○ High stress levels	○ Other_____	

IF FEMALE:

Do you still have periods?	○Yes ○ No	If no, what age did they stop?
Have your ovaries been removed?	○Yes ○ No	If yes, at what age?
Are you on hormone replacement?	○Yes ○ No	Age started_____Age stopped_____

DO YOU HAVE KNOWN ATRIAL FIBRILLATION (AF) ○ **YES or** ○ **NO** ***ONLY CHECK ONE***
If you answered YES, please check all spaces that apply to you

Type of AF (if known) _____	○ Intermittent	○ Continuous	○ Duration (if known) _____
Aware when you are in AF ○ Yes ○ No	Previous cardioversion? ○ Yes ○ No	Previous EP study? ○ Yes ○ No	Previous cardiac ablation? ○ Yes ○ No
Previous echocardiogram? ○ Yes ○ No	Pacemaker? ○ Yes ○ No	Type, brand and model (if known)	

MEDICATIONS:

Are you on cholesterol or lipid lowering medication?	○ Yes ○ No	How long?_____
Are you on high blood pressure medication?	○ Yes ○ No	How long?_____
Are you on daily aspirin?	○ Yes ○ No	How long?_____

PERTINENT MEDICATION LIST

Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency
Drug:	Dosage	Frequency

RECENT CARDIAC TESTS

Cardiac stress test in past year or scheduled?	○ Yes ○ No	Location	Date
Cardiac catheterization in past year or scheduled?	○ Yes ○ No	Location	Date
Cholesterol test in past year or scheduled?	○ Yes ○ No	Location	Date

PERTINENT SURGICAL PROCEDURES

○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:
○ Procedure:	○ Date:

CONTRAST CT / BETA BLOCKER CONTRAINDICATIONS

History of allergies ○ NO ○ YES ➤➤➤	○ Seasonal/hay fever ○ Xray dye/IV contrast	○ Shellfish ○ Asthma	○ Penicillin ○ Iodine	○ Demerol ○ Sulfa drugs
Please check if you currently have or have had any of the following:				
○ Previous X-ray dye injection	○ Irregular heart rate	○ Heart failure	○Pacemaker	
○ On chemotherapy	○ Kidney Problems	○ Multiple Myeloma	○ Liver Disease	

Is there any other significant medical or surgical history that you think we should know about? If so, please describe them in the space below.

_____
_____
_____
_____
_____
_____

If you do not have room for everything, please put the information on a separate sheet

It is important that we have a list of current medications and the dosages, especially any anti-arrhythmics AND Coumadin dose.

PLEASE FILL OUT THIS QUESTIONNAIRE AND HAVE IT READY FOR REVIEW WHEN YOU COME FOR YOUR APPOINTMENT.

This will help expedite your appointment duration. THANK-YOU