CAR DI AC MED ICA L H I S T O RY Q U E S T I O N NA I R E

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: __________________________________________

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PHYSICIAN INFORMATION: (If known)

Your Primary Care Doctor’s:
Name: _____________________________________________
Address: _____________________________________________ Suite # __________
City ___________________________ State _________ Zip code __________ Telephone Number ( ) __________

Your Cardiologist’s:
Name: _____________________________________________
Address: _____________________________________________ 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

Patient Questionnaire  01/06
DO YOU HAVE KNOWN HEART DISEASE
Please check all spaces that apply to you

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>Chest pain on exertion</td>
</tr>
<tr>
<td>Previous heart attack</td>
<td>Date:</td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>Date diagnosed:</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>Congenital heart disease Type:</td>
</tr>
</tbody>
</table>

DO YOU HAVE DISEASE IN ARTERIES OTHER THAN THE HEART
Please check all spaces that apply to you.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal insufficiency</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>Previous DVT (Leg or arm clots)</td>
<td>Other:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Sedentary lifestyle</th>
<th>Currently smoking</th>
<th>Quit smoking</th>
<th>Lifetime non-smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular exerciser How much?</td>
<td>Relatives with heart attack</td>
<td>Relatves with coronary artery disease</td>
<td>High cholesterol Value (if Known)</td>
</tr>
<tr>
<td></td>
<td>Immediate</td>
<td>Paternal</td>
<td>Maternal</td>
</tr>
<tr>
<td></td>
<td>Immediate</td>
<td>Paternal</td>
<td>Maternal</td>
</tr>
<tr>
<td>Overweight</td>
<td>High stress levels</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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)
If you answered YES, please check all spaces that apply to you

<table>
<thead>
<tr>
<th>Type of AF (if known)</th>
<th>Intermittent</th>
<th>Continuous</th>
<th>Duration (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware when you are in AF</td>
<td>Previous cardioversion?</td>
<td>Previous EP study?</td>
<td>Previous cardiac ablation?</td>
</tr>
<tr>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Previous echocardiogram?</td>
<td>Pacemaker?</td>
<td>Type, brand and model (if known)</td>
<td></td>
</tr>
<tr>
<td>Yes No</td>
<td>Yes No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:  

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:  

CONTRAST CT / BETA BLOCKER CONTRAINDICATIONS

History of allergies  
NO  YES  

Seasonal/hay fever  
Shellfish  
Penicillin  
Demerol  

Xray dye/IV contrast  
Asthma  
Iodine  
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

Patient Questionnaire  
01/06