Health Questionnaire

Name___________________________________ Date ___________________________

Date of Birth ____________________Age _________ Sex __________

Phone _________________________

Primary Care Physician _______________________________________ Phone ______________________

Reason for toady's visit: ____
Present Illness (Please circle one) Chest Pain No Yes

Shortness of breath No Yes

Palpitations No Yes Dizziness No Yes

Leg Swelling No Yes

How far can you walk? ____

Do you get pain in your legs when you walk? No Yes

Past Medical History (Please circle one)

Heart Attack No Yes When ___________

Angioplasty/Stenting No Yes When ___________

Diabetes Mellitus No Yes

Hypertension or taking medications for it No Yes

High Cholesterol or being treated for it No Yes

Stroke No Yes When ___________

Peripheral Vascular Disease No Yes

Chronic Lung Disease or Asthma No Yes

Bleeding disorder No Yes Other known health problems

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Past Surgical History (Please circle one) Coronary Artery Bypass Graft Surgery No Yes

When ___________ Valve Repair or Replacement No Yes When ___________

Pacemaker No Yes When ___________ Other
operations____

Family History (Please circle one) Heart Attack in a first-degree relative No Yes Who/Age ________

Heart Disease in a first-degree relative No Yes

Sudden Death No Yes

Social History (Please circle one) Do you smoke or have ever smoked? No Yes Quit date ________

Do you drink alcohol/beer? No Yes

Do you do any illicit drugs? No Yes Intravenous ______

Allergies (Please circle one) No Yes __________________________

List of Current Medications along with their Doses

1. _____________________________________
2. ____
3. _____________________________________
4. ____
5. _____________________________________
6. ____
7. _____________________________________
8. ____