NEW PATIENT QUESTIONNAIRE

Name:_________________________________ Primary Care Physician:__________________

Date of Birth: ___/___/___ Home Phone: (____) ___________ Cell Phone: (____) __________

Why are you seeing a cardiologist? (please answer in detail)

Have you ever seen a cardiologist before? Yes/No

If yes, what was the name of the cardiologist? ________________________________

Why did you see the cardiologist? (please answer in detail)

Please answer the following (circle yes or no. If yes, please describe)
Have you ever had:

Yes	No	a heart attack____
Yes	No	angina____
Yes	No	chest pain or pressure____
Yes	No	shortness of breath____
		(with stress, rest, or lying down)_____________________________________
Yes	No	palpitations, irregular heart beats, fast or slow heart rates____
Yes	No	fainting, near fainting, or dizziness__________________________________
Yes	No	heart murmur____
Yes	No	rheumatic fever____
Yes	No	congestive heart failure or heart enlargement____
Yes	No	swelling of your legs____
Yes	No	blue lips or fingernails____
Yes	No	leg pain or cramps when walking_____________________________________

\

Past Medical History

Do you have any of the following cardiac risk factors? (yes or no):

Yes No diabetes?
Yes No hypertension (high blood pressure)?
Yes No high cholesterol?
Yes No a history of smoking? If yes, packs per day____ # of years_____

Have you had any of the following? (circle yes or no):

Yes No a stress test?
Yes No an echocardiogram (ultrasound test of the heart)?
Yes No a coronary artery CT scan?
Yes No a heart catheterization?
Yes No an angioplasty or a stent?
Yes No heart, coronary, or valve surgery (open heart surgery)?
Yes No a pacemaker or a defibrillator?

Please list any other medical conditions that you have been diagnosed with:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Please list the names and year of any surgeries that you have had:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Men Only:

Please answer the following (circle yes or no. If yes, please describe):

Yes No hernia rupture?
____

Yes No prostate trouble?
____

MCVS MARYLAND CARDIOVASCULAR SPECIALISTS

Women Only:

Please answer the following: (circle yes or no. If yes, please describe):

Yes No Are you still having regular monthly menstrual periods?

____

Yes No Do you ever have bleeding between your periods?

____

Yes No Are you on or have you ever taken birth control pills?

____

Yes No Are you pregnant?

____

Yes No Have you ever had complications during pregnancy? (ie gestational diabetes)

____

How many children born alive?______
How many stillbirths?______
How many premature births?______
How many miscarriages?______
How many Cesarean operations?______
Date of last menstrual period?___/___/______

Medications

Please list all of the medications that you are currently taking (name/dose/frequency)

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Name any drugs to which you are allergic and describe your reaction:

Have you ever had an allergic reaction to x-ray contrast dye, iodine, or shellfish? If yes, please describe your reaction.

Family History

Has a family member had a heart attack, angina, heart failure, or another heart problem?

Yes No If yes to any, please describe:

____
____
____
____

MCVS MARYLAND CARDIOVASCULAR SPECIALISTS

Social History

Occupation ____
Marital Status ____
Education Level _______________________________________
How much alcohol do you drink? _________________________
How much coffee, tea, or colas do you drink daily?_______________
____
Do you exercise? ______________________________________
How many children do you have? _________________________
____

Review of Systems

Have you ever had any of the following? (circle yes or no. If yes, please describe):

Yes No a stroke or a small stroke? ______________________
Yes No frequent or severe headaches? ____________________
Yes No spells of weakness of an arm or leg? _______________
Yes No ringing in the ears? ___________________________
Yes No a seizure (convulsion)? _________________________
Yes No difficulty with speech? _________________________
Yes No loss of vision or double vision? ___________________
Yes No anemia? ____
Yes No problems with lungs, including wheezing or asthma? _________
Yes No problems with liver? ____________________________
Yes No problems with thyroid? __________________________
Yes No problems with kidneys? __________________________
Yes No cancer? ____
Yes No easy bleeding or bruising? _______________________
Yes No difficulty swallowing? ___________________________
Yes No hoarseness? ______________________________________
Yes No history of ulcers? _______________________________
Yes No history of a hiatal hernia? _______________________
Yes No blood in stools or black/tarry stools? _______________
Yes No diarrhea or constipation? ________________________
Yes No a recent weight loss or weight gain? _______________
Yes No recent fever or chills? __________________________
Yes No trouble starting to urinate? ______________________
Yes No blood in urine? __________________________________
Yes No kidney stones? ___________________________________
Yes No get up frequently at night to urinate? _______________
Yes No snoring loudly at night? _________________________
Yes No blood clots in lungs, legs, or elsewhere? ____________
Yes No varicose veins? __________________________________

Review of Systems

Have you ever had any of the following? (circle yes or no. If yes, please describe):

Yes	No	arthritis? ____________________
Yes	No	depression? ____________________
Yes	No	anxiety? ____________________
Yes	No	other psychiatric condition? ____________________
Yes	No	loss of sexual activity? ____________________
Yes	No	have you ever been subjected to any type of abuse (e.g. physical, sexual, or emotional? ____________________
Yes	No	have you ever been through any traumas? ____________________
Yes	No	do you feel safe in your home? ____________________

Is there any other important information that you wish to share with your cardiologist?

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Reviewed by: ____ Date: ____________________
Physician Signature