DALLAS CARDIOVASCULAR SPECIALISTS

New Patient Health Questionnaire

Date:____/ ____/_____

Patient: _____ Gender: ☐M ☐F

Date of birth:_____/_____/_____; Age:_____;

Referring Doctor:_____

Please INDICATE all the reasons for your visit.

1. ☐Chest pain ☐at rest ☐with exertion
2. ☐Shortness of Breath ☐at rest ☐with exertion
3. ☐Palpitations / irregular heart rate
4. ☐Racing heart
5. ☐Swelling legs
6. ☐Dizziness / Fainting
7. ☐Hypertension
8. ☐Heart failure
9. ☐Pre surgical evaluation
10. ☐Establish new cardiologist

H1. PRIOR HEART DISEASE AND TESTING? ☐YES: ☐NO (Next Section)

Heart murmur / valve prolapse ☐NO ☐YES: YEAR; _____

Rheumatic / Scarlet fever ☐NO ☐YES: YEAR; _____

Angina / Chest pain ☐NO ☐YES: YEAR; _____

Heart attack ☐NO ☐YES: YEAR; _____ Location: _____

Heart Cath / Angioplasty / Stent ☐NO ☐YES: YEAR; _____ Location: _____

Bypass surgery ☐NO ☐YES: YEAR; _____ Location: _____

Pacemaker ☐NO ☐YES: YEAR; _____ Location: _____

Defibrillator ☐NO ☐YES: YEAR; _____ Location: _____

Heart failure ☐NO ☐YES: YEAR; _____

Stress test (treadmill) ☐NO ☐YES: YEAR; _____ Location: _____

Echo / Ultrasound ☐NO ☐YES: YEAR; _____ Location: _____

Calcium Scoring ☐NO ☐YES: YEAR; _____ Location: _____

Nuclear Thallium PET Scan ☐NO ☐YES: YEAR; _____ Location: _____

Carotid ultrasound ☐NO ☐YES: YEAR; _____ Location: _____

CT Angiogram ☐NO ☐YES: YEAR; _____ Location: _____

Holter (24 hr monitor) ☐NO ☐YES: YEAR; _____ Location: _____

H2. RISK FACTORS FOR HEART DISEASE:

High cholesterol ☐NO ☐YES: YEAR; _____ TC___LDL___HDL___TG____

High blood pressure ☐NO ☐YES: YEAR; _____

Diabetes ☐NO ☐YES: YEAR; _____ Hormones ☐Y / ☐N

Current Smoker ☐NO ☐YES

Previous Smoker ☐NO ☐YES QUIT YEAR; _____

Phen / Fen weight loss medicine ☐NO ☐YES: YEAR; _____

H3. BLOOD VESSEL DISEASES

Carotid disease or endarterectomy ☐NO ☐YES: YEAR; _____

Stroke or TIA (ministroke) ☐NO ☐YES: YEAR; _____

Aortic aneurysm ☐NO ☐YES: YEAR; _____ Surgical Repair YEAR;_____

Numbness or tingling of legs ☐NO ☐YES: YEAR; _____

Leg cramps while walking ☐NO ☐YES: YEAR; _____

Venous thrombosis (leg clots) ☐NO ☐YES: YEAR; _____

Pulmonary embolism (lung clots) ☐NO ☐YES: YEAR; _____

MEDICATIONS:

Please list all prescription and non-prescription medicines including vitamins and aspirin.

	NAME	DOSE/STRENGTH	FREQUENCY
Example	Lasix	40 mg.	2 in am / 1 in pm
1.	_____	_____	_____ / _____
2.	_____	_____	_____ / _____
3.	_____	_____	_____ / _____
4.	_____	_____	_____ / _____
5.	_____	_____	_____ / _____
6.	_____	_____	_____ / _____
7.	_____	_____	_____ / _____
8.	_____	_____	_____ / _____
9.	_____	_____	_____ / _____
10.	_____	_____	_____ / _____
11.	_____	_____	_____ / _____
12.	_____	_____	_____ / _____

H4. DO YOU HAVE ANY ALLERGIES TO MEDICINES? ☐ NO (next section) ☐ YES

Please list all medications to which you have an allergy or adverse response and list the reaction (e.g. penicillin-arm rash)

	Medication	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Are you allergic to iodine, shrimp or shellfish? ☐ NO ☐ YES

Have you received X-ray contrast (myleogram, IVP, CT Scan)? ☐ NO ☐ YES

If Yes, did you have any reaction to the contrast? ☐ NO ☐ YES

H5. PAST SURGICAL HISTORY (OPERATIONS) ☐ NO ☐ YES

Do not relist the cardiac operations already listed.

Example	appendectomy	YEAR; 95	Location: Medical City
1.	_____	YEAR;_____	Location_____
2.	_____	YEAR;_____	Location_____
3.	_____	YEAR;_____	Location_____
4.	_____	YEAR;_____	Location_____
5.	_____	YEAR;_____	Location_____
6.	_____	YEAR;_____	Location_____

DALLAS CARDIOVASCULAR SPECIALISTS

Family History: Please indicate in the spaces below any family members with a history of: tuberculosis, diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gall bladder disease.

	Age	Health Problems	Age at Death	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers				
(how many in all?_____)				
Sisters				
(how many in all?_____)				
Sons				
(how many in all?_____)				
Daughters				
(how many in all?_____)				

Any other family members with illnesses noted above?_____

REVIEW OF SYSTEMS: Please check any and all conditions that you have.

GENERAL
- ☐ Cancer: list site: _____
  - If yes, Chemotherapy? ☐ Y / ☐ N
  - If yes, Radiation? ☐ Y / ☐ N

ENDOCRINE
- ☐ Low thyroid
- ☐ Pre-diabetes / ☐ high blood sugar

EYES ☐ glasses / ☐ contacts
- ☐ Glaucoma
- ☐ Cataracts
  - If Yes, Removed? ☐ Y / ☐ N

LUNG / BREATHING
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Snoring / ☐ Sleep apnea / ☐ CPAP
- ☐ Have you had a sleep study?
  - If so, year:_____

INFECTIOUS DISEASES
- ☐ AIDS / ☐ HIV
- ☐ MRSA
- ☐ Hepatitis ☐ A / ☐ B / ☐ C

EARS
- ☐ Hearing loss
- ☐ Hearing Aids

NEUROLOGICAL
- ☐ Loss of consciousness
- ☐ Seizures / ☐ epilepsy
- ☐ Headaches / ☐ migraines

ABDOMEN
- ☐ Hiatus hernia
- ☐ Reflux disease / ☐ GERD
- ☐ Ulcer disease

KIDNEY / BLADDER
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Problems

MUSCLE/JOINT
- ☐ Osteoarthritis
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis

VASCULAR DISEASE
- ☐ Poor circulation
- ☐ History of vein stripping

BLOOD

Have you ever taken:
- Coumadin ☐ Y / ☐ N
- Warfarin ☐ Y / ☐ N

- ☐ Clotting problems
- ☐ Bleeding problems
- ☐ Leukemia
- ☐ Anemia

MOBILITY
- Difficulty walking? ☐ Y / ☐ N
- Do you use a cane? ☐ Y / ☐ N
- Wheelchair? ☐ Y / ☐ N

PSYCHIATRIC
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety
- ☐ Panic attacks

OTHER CONDITIONS

_____

_____

_____

_____

_____

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SOCIAL HISTORY

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Number of Children:_____ With whom do you live?_____

Family Physician:_____

Your other physicians: 1)_____

2)_____

What is/was your occupation?_____ ☐ N/A

Are you retired? ☐ Yes ☐ No

How stressful is your job? ☐ Very ☐ Moderately ☐ Mildly ☐ Not ☐ N/A

Do you take your prescribed medications regularly?

☐ Always ☐ Most of the time ☐ I frequently skip doses

Have you previously smoked?

☐ Never

☐ Yes, but quit YEAR_____ # of packs/day_____ from age____ to age_____

☐ Currently smoking #of packs/day_____ from age____ to age_____

☐ Cigars ☐ Pipe ☐ Chew tobacco: times / day_____

Do you drink alcohol?

☐ Never ☐ No, but I quit YEAR:_____

☐ Yes, _____ glasses/week of ☐ wine ☐ beer ☐ liquor

Do you take illicit drugs or abuse prescription medications:

☐ Never ☐ No, but I used to ☐ Yes DETAILS:_____

Do you drink caffeine? ☐ No ☐ Yes: *(check all that apply)* ☐ Coffee ☐ Tea ☐ Colas

Total # Drinks/day: _____

How many times/week do you exercise?_____ How many hrs/session?_____

What type of exercise do you do? *(check all that apply)*

☐ Walking ☐ Sports ☐ Golf ☐ Treadmill

☐ Cycling ☐ Weight Lifting ☐ Dancing ☐ Elliptical

☐ Swimming ☐ Aerobics ☐ Running ☐ Other

Diet: ☐ American Heart Step I ☐ Atkins ☐ Diabetic ☐ South Beach

☐ Mainly Red Meat ☐ Mainly White Meat ☐ Vegetarian ☐ Low Sodium

☐ Low fat, Low Cholesterol ☐ None of the above

I have provided the above medical history and verify that it is accurate and complete:

Patient signature_____ Date:_____

I have reviewed the above information with the patient:_____ RN, PA, ACNP

Patient Health History has been reviewed by_____ on _____

(Physician signature) (date)