



## New Patient Health Questionnaire

CARDIAC ASSOCIATES OF DALLAS | 7777 Forest Lane, C-655 | Dallas TX 75230 | 972 566 8474

---

**Date:** \_\_\_/\_\_\_/\_\_\_

**Patient:** \_\_\_\_\_ **Date of birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_ **Gender:** M F

**Occupation:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

**Please INDICATE all the reasons for your visit.**

- Chest pain
- Shortness of Breath
- Palpitations
- Heart murmur
- Abnormal rhythm
- Dizziness / Fainting
- Hypertension
- Heart failure / Swollen Legs
- Pre surgical evaluation
- Screening cardiac evaluation
- Establish new cardiologist.

### H1. PRIOR HEART DISEASE AND TESTING?

**YES : NO (If No, skip to next section)**

Heart murmur/valve prolapse	NO	YES	(If yes what year? _____)	
Rheumatic /Scarlet fever.....	NO	YES	(If yes what year? _____)	
Angina.....	NO	YES	(If yes what year? _____)	
Heart attack.....	NO	YES	(If yes what year? _____)	Location? _____
Heart Cath/ Angioplasty /Stent	NO	YES	(If yes what year? _____)	Location? _____
Bypass surgery.....	NO	YES	(If yes what year? _____)	Location? _____
Pacemaker .....	NO	YES	(If yes what year? _____)	Location? _____
Defibrillator (AICD) .....	NO	YES	(If yes what year? _____)	Location? _____
Heart failure.....	NO	YES	(If yes what year? _____)	
Stress test (treadmill)...	NO	YES	(If yes what year? _____)	Location? _____
Echo / Ultrasound.....	NO	YES	(If yes what year? _____)	Location? _____
Nuclear Thallium PET scan.....	NO	YES	(If yes what year? _____)	Location? _____
Carotid ultrasound.....	NO	YES	(If yes what year? _____)	Location? _____
Holter (24hr tape) .....	NO	YES	(If yes what year? _____)	Location? _____

### H2. WHICH OF THESE RISK FACTORS FOR HEART DISEASE DO YOU HAVE:

High cholesterol.....	NO	YES	(If yes what year? _____)	TC___ LDL___ HDL___ TG___
High blood pressure.....	NO	YES	(If yes what year? _____)	
Diabetes.....	NO	YES	(If yes what year? _____)	
Female menopause.....	NO	YES	(If yes what year? _____)	Hormones Y / N
Current/recent smoker.....	NO	YES:	(Quit what year? _____)	

**H3. BLOOD VESSEL DISEASES**

Carotid disease or endarterectomy...	NO	YES:YEAR;_____
Stroke or TIA (ministroke).....	NO	YES:YEAR;_____
Aortic aneurysm.....	NO	YES:YEAR;_____
Poor leg circulation.....	NO	YES:YEAR;_____
Leg cramps while walking.....	NO	YES:YEAR;_____
Venous thrombosis (leg clots).....	NO	YES:YEAR;_____
Pulmonary embolism (lung clots)....	NO	YES:YEAR;_____

**H4. 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:\_\_\_\_\_

**H5. 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.	_____	_____	_____ / _____

**H6. DO YOU HAVE ANY ALLERGIES TO MEDICINES?                      NO                      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. _____	_____

**H7. MEDICAL HISTORY: WILL BE FILLED OUT BY NURSING STAFF**

1. Hepatitis/Jaundice	NO	YES	YEAR:_____
2. Asthma	NO	YES	YEAR:_____
3. Peptic ulcer	NO	YES	YEAR:_____
4. _____			
5. _____			

**H8. SOCIAL HISTORY:**

Marital Status:      Married      Separated      Divorced      Widowed      Single

How many hours per week do you spend active? \_\_\_\_\_hours

Do you drink alcohol 1. Never

2. I did, but I quit YEAR: \_\_\_\_\_

3. Yes, \_\_\_\_\_ drinks per week.

**H9. FAMILY HISTORY**

ILLNESS	FATHER	MOTHER	BROTHER	SISTER	SON/S	DAUGHTER/S
LIVING	Y/N	Y/N				
AGE/S						
Heart attack, angina, coronary bypass or angioplasty under age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack, angina, coronary bypass or angioplasty age 55-65	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke under age 65	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*(Please fill out details of your biologic relatives)***H10. REVIEW OF SYSTEMS:***Check any and all conditions that you have***GENERAL** Cancer: (list site: \_\_\_\_\_)**ENDOCRINE** Low thyroid**EYES** Glaucoma Cataracts**LUNG/BREATHING** Persistent Cough Bronchitis Emphysema**NEUROLOGICAL** Seizures/epilepsy**ABDOMEN** Hiatus hernia Heartburn**KIDNEY/BLADDER** Dialysis Kidney Stones**INFECTIONS** AIDS/HIV**BLOOD** Bleeding problems Leukemia

I have reviewed the above information

with the patient on Date: \_\_\_\_\_

Signed: \_\_\_\_\_