New Patient Health Questionnaire

CARDIAC ASSOCIATES OF DALLAS | 7777 Forest Lane, B-432 | 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. HAVE YOU HAD HEART DISEASE AND/OR PRIOR 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? ____________)
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? YES NO
Current/Recent Smoker	NO	YES	(Quit what year? ____________)	
Phen/Fen Weight Loss Medicine	NO	YES	(If yes, what year? ____________)	

H3. BLOOD VESSEL DISEASES

Carotid Disease or Endarterectomy	NO	YES	(If yes, what year? ____________)
Stroke or TIA (mini-stroke)	NO	YES	(If yes, what year? ____________)
Aortic Aneurysm	NO	YES	(If yes, what year? ____________)
Poor Leg Circulation	NO	YES	(If yes, what year? ____________)
Leg Cramps While Walking	NO	YES	(If yes, what year? ____________)
Venous Thrombosis (leg clots)	NO	YES	(If yes, what year? ____________)
Pulmonary Embolism (lung clots)	NO	YES	(If yes, what year? ____________)

H4. PAST SURGICAL HISTORY (OPERATIONS) **NO** **YES**

Do not relist the cardiac operations already listed.

Example: Appendectomy YEAR: 1995 Location: Medical City Dallas

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? **YES** **NO** *(if No, skip to next section)*

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 STAF F******

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 ❑ Never

❑ I did, but have quit. (Year:_______________)

❑ Yes, _______ drinks per week.

H9. FAMILY HISTORY *(Please fill out details of your biological relatives)*

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	❑	❑	❑	❑	❑	❑
Heart attack, angina, coronary bypass or angioplasty age 55-65	❑	❑	❑	❑	❑	❑
Stroke under age 65	❑	❑	❑	❑	❑	❑
Sudden Death	❑	❑	❑	❑	❑	❑

H10. REVIEW OF SYSTEMS:

Check any and all conditions 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 ______________________________________