CARDIAC MEDICAL QUESTIONNAIRE

(Confidential) Appointment Date: _____

Patient Name:_____ Date of Birth: _____ Age: _____

Occupation:_____ ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Disabled

Previous Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Other

Referring Physician _____ Reason for referral _____

CHEST PAIN ☐ Yes ☐ No

When did it start? _____ Where is the pain located? _____

Character of the pain: ☐ Sharp ☐ Stabbing ☐ Pressure ☐ Burning Pain ☐ Chest Heaviness ☐Dull Ache

Severity of Pain: 1 2 3 4 5 6 7 8 9 10 Is it worsened with exertion? Yes No

Does it occur at rest? ☐ Yes ☐ No It is associated with meals? ☐ Yes ☐ No

Does it occur at any particular time? ☐ Yes ☐ No How many times a day/week? _____

Is it associated with any symptoms of shortness of breath, weakness, sweatiness? ☐ Yes ☐ No

Does this pain stop you from doing your housework or functioning? ☐ Yes ☐ No

PALPATATIONS (When you are aware of you heart beating, it can be fast or slow) ☐ Yes ☐ No

How long do these palpations last? _____

Is it associated with symptoms of shortness of breath, weakness, fainting spells? ☐ Yes ☐ No

Does it: ☐ Start suddenly and stop suddenly or ☐ Start suddenly and slowly stop

How many episodes do you have per week? _____ Per day? _____

Is it: ☐ regular or ☐ irregular? Any history of thyroid problems? ☐ Yes ☐ No

Do you drink coca-cola, tea, coffee, alcohol? ☐ No ☐ Yes How much per day? _____

Have you been under a lot of stress recently? ☐ No ☐ Yes If yes, why? _____

FAMILY HISTORY

List parents and all brothers and sisters. If deceased, please list age at death and cause of death.

	Living?	Age	Any known medical conditions or cause of death
Mother:			
Father:			
Sisters:			
Brothers:			

HISTORY / RISK FACTORS

History of high blood pressure? ☐ Yes ☐ No ☐ Unknown How long?_____

Any complications? _____

Diabetes? ☐ Yes ☐ No How long? _____ Any complications?_____

Smoking? ☐ Yes ☐ No How long?_____ How Many cigarettes per day?_____

Have you smoked in the past? ☐ Yes ☐ No If yes, for how long? _____

Any History of: ☐ HIV ☐ TB ☐ Hepatitis ☐ Alcoholism

How much alcohol do you consume per day? _____

Do you use sedatives to help you sleep? Yes No

How many caffeinated beverages do you consume per day? _____

When was your last Dentist visit? _____

History of high Cholesterol? ☐ Yes ☐ No

Any family history of heart disease? ☐ Yes ☐ No If yes, list who: _____

Do you have any history of kidney disease? ☐ Yes ☐ No If yes, what type? _____

Any history of previous stroke? ☐ Yes ☐ No If yes, when? _____

Any history of blockage of the arteries in the legs or neck? ☐ Yes ☐ No

Any history of chronic lung disease? ☐ Yes ☐ No

Any history of previous heart attack or angina? ☐ Yes ☐No *If yes to heart attack, how long ago? _____

Previous cardiac angiogram? ☐Yes ☐No If yes, where and when done? _____

Do you exercise? ☐ Yes ☐ No How many times per week? _____

What type of exercise do you perform? _____

Females: Any history of polyovarian syndrome? ☐ Yes ☐ No

Have you ever been treated for infertility? ☐ Yes ☐ No

PAST SURGERIES

Year	Operations	Place Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

Name	Dose	Name	Dose
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

DRUG ALLERGIES

Please list any allergies or reactions to medicines or other substances

Name of Medicine	Type of Reaction

Do you currently have or had in the past any of the following?

RESPIRATORY	Y	N	**CARDIOVASCULAR**	Y	N
Cough			Do you wake up at night short of breath		
Wheeze			Any swelling of the legs		
Coughing up blood			Any history of rheumatic fever		
Shortness of breath			Any history of heart murmur		
Asthma			Any history of congenital heart disease		
COPD			How many pillows do you sleep on		
History of clotting in the legs			**SLEEP & MOOD DISORDER**	Y	N
History of pulmonary embolus			Difficulty falling asleep		
GASTROINTESTINAL TRACT	Y	N	Wake up early in the morning and cannot sleep		
Do you eat a lot of vegetables			Feel depressed		
Do you have a good appetite			Have you ever been treated for anxiety disorder		
Weight loss over the past 6 months			Have you ever been treated for depression		
Heartburn			Do you nap in the daytime: how long_____		
Abdominal Pain			Do you wake up with early morning headaches		
History of peptic ulcer			Dry mouth in the morning		
History of GI bleed			Episodes of choking at night		
Diarrhea			Weight gain in the past 6 months? _____lbs		
Constipation			Do you snore		
Cancer of the GI tract			History of daytime fatigue		
Bleeding disorder			Have you been told you stop breathing		
NEUROLOGICAL	Y	N	**MUSCULOSKELETAL**	Y	N
Loss of vision in one or both eyes			History of rheumatoid arthritis		
Weakness of the legs or arms			History of degenerative arthritis		
History of headaches			History of Raynaud's Phenomenon		
History of migraines			History of Scleroderma		
Pins and needles in arms or legs			History of Radiation treatment		
Numbness of feet or hands			History of Systemic Lupus Erythematosus		
History of seizure			**GENITOURINARY**		
History of Multiple Sclerosis			Burning during urination		
			Blood in the urine		

Have you had any recent blood tests, EKGs, or other tests – CT, MRI? ☐ Yes ☐ No

Name of test	Where it was done