Baylor Scott & White
DENTON HEART GROUP

A member of HealthTexas Provider Network

New Patient Questionnaire

Name:_____Date of Birth: _____

Reason for visit: _____

All physicians you currently see:_____

_____

Current Medication: (please put name and dosage) _____

_____

_____

_____

Preferred Pharmacies_____

Allergies and reactions: _____

_____

Please circle past medical history:

Diabetes	High Blood Pressure	High Cholesterol	Heart attack
Heart Failure	Irregular heart rhythm	Emphysema	Asthma Reflux
Sleep apnea	Stroke	Seizures	Kidney disease
Liver	Gallbladder	Pancreas	Blood clots
Thyroid	Cancer: _____	Anemia	Carotid Disease
Arthritis	Gout	Atrial Fibrillation	

Other: _____

Past Surgical History:	Where	Year	Surgeon
__Heart Bypass Surgery:	_____	_____	_____
__Heart Valve repair/replaced:	_____	_____	_____
__Aneurysm repair:	_____	_____	_____
__Ablation:	_____	_____	_____
__Pacemaker or ICD: (Brand :_____)	_____	_____	_____
__Hernia	_____	_____	_____
__Appendectomy	_____	_____	_____
__Gallbladder	_____	_____	_____
__Shoulder	_____	_____	_____
__Hip	_____	_____	_____
__Knee	_____	_____	_____
__Hysterectomy	_____	_____	_____

Recent testing:	Where	Year		Where	Year
__CT	_____	_____	__ Monitor	_____	_____
__Echo	_____	_____	__Ultrasound	_____	_____
__Stress test	_____	_____	__ MRI	_____	_____
__Coronary calcium score	_____	_____	__ ABI	_____	_____
__Lab					

Have you had any pain in your legs, hips, or lower back: Y N

Do you have any wounds or open sores on your feet: Y N

Social History: (Circle one)

Marital Status: Married Single Divorced Widow

Drinking: Yes No If yes, how much: _____ how often: _____

Tobacco: Smoking Yes No Former Packs per day_____ Years_____

Smokeless: Snuff Chew E-cig Former

Family History:	Living		Bypass	HBP	Chol	AAA	Diabetes	Cancer	Stroke	Sudden death
Mother:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐
Father:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐
Brother:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐
Sister:	Y	N	☐	☐	☐	☐	☐	☐	☐	☐