The Heart Group

New Patient Health Questionnaire Date:_____

Patient: _____ Gender: ○ M ○ F

Date of birth: _____; Age:_____; Occupation: _____

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 (AICD)	○ 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 (24hr 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;	_____	
Female menopause	○ 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.			/

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: _____

H6. MEDICAL HISTORY:

1. Hepatitis/Jaundice ◯ NO ◯ YES YEAR _____
2. Asthma ◯ NO ◯ YES YEAR _____
3. Peptic Ulcer ◯ NO ◯ YES YEAR _____
4. _____

FAMILY HISTORY

Please indicate with a check mark all those immediate family members with the following conditions.

	Father	Mother	Brother 1	Brother 2	Sister 1	Sister 2	Children
1.) Angina	☐	☐	☐	☐	☐	☐	☐
2.) Heart Attack	☐	☐	☐	☐	☐	☐	☐
3.) Angioplasty / Stent	☐	☐	☐	☐	☐	☐	☐
4.) Heart Bypass	☐	☐	☐	☐	☐	☐	☐
5.) Other Heart Surgery	☐	☐	☐	☐	☐	☐	☐
6.) Heart Failure	☐	☐	☐	☐	☐	☐	☐
7.) Stroke	☐	☐	☐	☐	☐	☐	☐
8.) Heart Valve Problem	☐	☐	☐	☐	☐	☐	☐
9.) Congenital Heart Disease	☐	☐	☐	☐	☐	☐	☐
10.) Hypertension	☐	☐	☐	☐	☐	☐	☐
11.) Abnormal Cholesterol / Triglyceride	☐	☐	☐	☐	☐	☐	☐
12.) Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐
13.) Abdominal Aortic Aneurysm	☐	☐	☐	☐	☐	☐	☐
14.) Pacemaker / AICD	☐	☐	☐	☐	☐	☐	☐
15.) Sudden Death	☐	☐	☐	☐	☐	☐	☐

Father's age at death, if deceased _____

Mother's age at death, if deceased _____

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

GENERAL

☐ Cancer: list site: _____

If yes, Chemotherapy? Y N

ENDOCRINE

☐ Low thyroid

☐ Pre-diabetes / high blood sugar

EYES

☐ Glaucoma

☐ Cataracts? Y N

If Yes, Removed? Y N

LUNG / BREATHING

☐ Asthma

☐ Bronchitis

☐ Emphysema

☐ Snoring ☐ Sleep apnea ☐ CPAP

INFECTIONS

☐ AIDS/HIV

NEUROLOGICAL

☐ Loss of consciousness

☐ Seizures ☐ Epilepsy

☐ Headaches ☐ Migraines

ABDOMEN

☐ Hiatus hernia

☐ Reflux disease

☐ Ulcer disease

KIDNEY / BLADDER

☐ Dialysis

☐ Kidney stones

☐ Prostate problems

MUSCLE / JOINT

☐ Arthritis

☐ Chronic back pain

BLOOD

Have you ever taken:

Coumadin Y N

Warfarin Y N

☐ Clotting problems

☐ Bleeding problems

☐ Leukemia

☐ Anemia

PSYCHIATRIC

☐ Depression

☐ Bipolar disorder

☐ Anxiety

☐ Panic attacks

Other Conditions?

_____

_____

_____

_____

The Heart Group

SOCIAL HISTORY

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

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

Family Physician: _____

Your other Physicians: 1) _____

2) _____

Are you retired? ◯ Yes ◯ No

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

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

Do you take your prescribed medications regularly?

◯ 1. Always ◯ 2. Most of the time ◯ 3. I frequently skip doses

Have you previously smoked?

◯ 1. Never
◯ 2. Yes, I quit YEAR _____ # of packs/day _____ # of years smoking _____
◯ 3. Currently smoking # of packs/day _____
☐ Cigars ☐ Pipe ☐ Chew tobacco _____ times / day

Do you drink alcohol?

◯ 1. Never ◯ 2. No, but I quit YEAR: _____
◯ 3. Yes, _____ glasses/week of ☐ wine ☐ beer ☐ liquor

Do you take illicit drugs or abuse prescription medications:

◯ 1. Never ◯ 2. No, but I used to ◯ 3. Yes DETAILS: _____

Do you drink caffeine? ◯ No ◯ Yes: *(circle all that apply)* ☐ Coffee ☐ Tea ☐ Soft drinks _____ Drinks/ day

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

What type of exercise do you do: *(circle 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)