



## Patient Questionnaire

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Name of Physician providing your general care: \_\_\_\_\_

Describe briefly your present symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CARDIAC RISK FACTORS:

Smoker?	_____	How much or when did you quit?	_____
High blood pressure?	_____	How long has it been present?	_____
Diabetes mellitus?	_____	How long has it been present?	_____
Cholesterol elevation?	_____	How high has it been?	_____
Family with heart disease?	_____		_____

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS: (name, dose, how often) (Heart related first)**

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

**SURGERIES OR PROCEDURES (Heart related first)**

**OPERATION**

**DATE**

**HOSPITAL**

**DOCTOR**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**OTHER MEDICAL ILLNESSES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please use back of this page for any additional information.

**Heartland Cardiology, P.A.**  
**Health-Related Questions (Please circle and fill in responses.)**

- Yes No ??? Has your weight changed significantly? How has it changed?
- Yes No ??? Do you ever get dizzy or pass out?
- Yes No ??? Have you briefly lost your vision, especially in just one eye?
- Yes No ??? Are you ever short of breath?
- Yes No ??? Do you have difficulty breathing lying down flat?
- Yes No ??? Do you wake up in the middle of the night in order to breathe?
- Yes No ??? Do you ever have chest discomfort? If yes, fill in below.
- Where is the chest discomfort?
- What does the chest discomfort feel like?
- Where does the chest discomfort go?
- What makes the chest discomfort begin?
- What makes the chest discomfort stop?
- Yes No ??? Do you ever have heart palpitations, skipping or fluttering, If yes, fill in below.
- When do these palpitations occur?
- What makes these palpitations begin?
- What makes these palpitations stop?
- Do you ever feel any other symptoms during the palpitations?
- Yes No ??? Do your legs ever swell up?
- What is the most physical/recreation that you have recently performed?
- Yes No ??? Do you use alcoholic beverages? How much?
- Yes No ??? Do you use caffeinated beverages? How much?
- Yes No ??? Are you employed? List your job description.