Centennial Heart CARDIOVASCULAR CONSULTANTS

New Patient Questionnaire

Patient Name _____ MR# _____ Date _____

Birthday _____ Age _____ Primary Care MD or Referring MD _____

Pharmacy/Address/City/State/Zip _____ Phone # _____

Reason for today's visit _____ Recent Testing (radiology, procedure, lab work?) ☐ **Yes** ☐ **No**

What? _____ Where? _____

Past medical and surgical history? _____

Medical History:

Have you recently or are you currently experiencing any of the following conditions? (check Yes or No)

Constitutional:
Yes No
- ☐ ☐ fever
- ☐ ☐ chills
- ☐ ☐ night sweats
- ☐ ☐ fatigue
- ☐ ☐ weakness
- ☐ ☐ light headedness

Head, Eyes, Ears, Nose, Throat:
- ☐ ☐ eye problems
- ☐ ☐ ear problems
- ☐ ☐ difficulty swallowing

Neurological:
- ☐ ☐ seizures
- ☐ ☐ stroke
- ☐ ☐ passing out
- ☐ ☐ dizziness

Blood:
Yes No
- ☐ ☐ excessive bleeding
- ☐ ☐ excessive bruising
- ☐ ☐ deep vein thrombosis
- ☐ ☐ pulmonary embolism

Vascular:
- ☐ ☐ claudication

Cardiac:
- ☐ ☐ difficulty breathing
- ☐ ☐ diff. breathing sleeping
- ☐ ☐ diff. breathing walking
- ☐ ☐ murmur
- ☐ ☐ rheumatic fever
- ☐ ☐ palpitations
- ☐ ☐ chest pain
- ☐ ☐ chronic malaise

Skin:
- ☐ ☐ rash
- ☐ ☐ lesions
- ☐ ☐ cancer

Pulmonary:
Yes No
- ☐ ☐ asthma
- ☐ ☐ coughing
- ☐ ☐ productive coughing
- ☐ ☐ tuberculosis
- ☐ ☐ sleep apnea

Muscular/Skeletal:
Yes No
- ☐ ☐ osteoarthritis
- ☐ ☐ joint pain
- ☐ ☐ muscle pain
- ☐ ☐ rheumatoid arthritis

Gastrointestinal:
- ☐ ☐ change in stool
- ☐ ☐ blood in stool

Genitourinary:
- ☐ ☐ difficulty urinating
- ☐ ☐ blood in urine
- ☐ ☐ urinary tract infection
- ☐ ☐ renal failure
- ☐ ☐ kidney stones

Psychiatric
- ☐ ☐ depression
- ☐ ☐ anxiety

Are you allergic to any medications? ☐ Yes ☐ No (list) _____

_____

Are you allergic to IV Dye/Contrast? ☐ Yes ☐ No

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Do you have an Advanced Plan of Care/Directive?** ☐ Yes ☐ No

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled **Occupation:** _____

Exercise? ☐ Yes ☐ No **What do you do and how often?** _____

Caffeine? ☐ Yes ☐ No **What and how much?** _____

Smoke? ☐ Yes ☐ No **How many packs per day?** _____ **How long?** _____ **Interested in Quitting?** ☐ Yes ☐ No

Alcohol? ☐ Yes ☐ No **What and how much?** _____

Recreational Drugs? ☐ Yes ☐ No **What and how much?** _____

Cardiac Risk Factors: **Diabetes?** ☐ Yes ☐ No **High Blood Pressure?** ☐ Yes ☐ No **High Cholesterol?** ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No **Use Tobacco?** ☐ Yes ☐ No **Use Alcohol?** ☐ Yes ☐ No

Have you received the annual flu vaccination? ☐ Yes ☐ No **Pneumonia vaccination within the last 5 yrs?** ☐ Yes ☐ No

Are you currently taking an Aspirin or other antiplatelet daily? ☐ Yes ☐ No **If other, what?** _____

Family History:

Are there members of your immediate family with the following conditions or history?

Heart Disease? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Heart surgery? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Irregular heart rhythms? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Physician Signature _____