New Patient Questionnaire

Name:_____ Primary Care Physician:_____

Date of Birth: ___/___/___ Home Phone: (____) _____ Cell Phone: (____) _____

Why are you seeing a cardiologist? (please answer in detail)

Have you ever seen a cardiologist before? Yes/No

If yes, what was the name of the cardiologist? _____

Why did you see the cardiologist? (please answer in detail)

Please answer the following (circle yes or no. If yes, please describe)
Have you ever had:

Yes	No	a heart attack_____
Yes	No	angina_____
Yes	No	chest pain or pressure_____
Yes	No	shortness of breath_____ (with stress, rest, or lying down)_____
Yes	No	palpitations, irregular heart beats, fast or slow heart rates_____
Yes	No	fainting, near fainting, or dizziness_____
Yes	No	heart murmur_____
Yes	No	rheumatic fever_____
Yes	No	congestive heart failure or heart enlargement_____
Yes	No	swelling of your legs_____
Yes	No	blue lips or fingernails_____
Yes	No	leg pain or cramps when walking_____

\

MCVS
MARYLAND
CARDIOVASCULAR
SPECIALISTS

Past Medical History

Do you have any of the following cardiac risk factors? (yes or no):

Yes No diabetes?
Yes No hypertension (high blood pressure)?
Yes No high cholesterol?
Yes No a history of smoking? If yes, packs per day____ # of years_____

Have you had any of the following? (circle yes or no):

Yes No a stress test?
Yes No an echocardiogram (ultrasound test of the heart)?
Yes No a coronary artery CT scan?
Yes No a heart catheterization?
Yes No an angioplasty or a stent?
Yes No heart, coronary, or valve surgery (open heart surgery)?
Yes No a pacemaker or a defibrillator?

Please list any other medical conditions that you have been diagnosed with:

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

Please list the names and year of any surgeries that you have had:

_____ _____
_____ _____
_____ _____
_____ _____

Men Only:

Please answer the following (circle yes or no. If yes, please describe):

Yes No hernia rupture?
_____

Yes No prostate trouble?
_____

Women Only:

Please answer the following: (circle yes or no. If yes, please describe):

Yes No Are you still having regular monthly menstrual periods?
_____

Yes No Do you ever have bleeding between your periods?
_____

Yes No Are you on or have you ever taken birth control pills?
_____

Yes No Are you pregnant?
_____

Yes No Have you ever had complications during pregnancy? (ie gestational diabetes)
_____

How many children born alive?_____ How many miscarriages?_____
How many stillbirths?_____ How many Cesarean operations?_____
How many premature births?_____ Date of last menstrual period?___/___/_____

Medications

Please list all of the medications that you are currently taking (name/dose/frequency)

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

Name any drugs to which you are allergic and describe your reaction:

Have you ever had an allergic reaction to x-ray contrast dye, iodine, or shellfish? If yes, please describe your reaction.

Family History

Has a family member had a heart attack, angina, heart failure, or another heart problem?

Yes No If yes to any, please describe:

_____
_____
_____
_____

MCVS
MARYLAND
CARDIOVASCULAR
SPECIALISTS

Social History

Occupation _____
Marital Status _____
Education Level _____
How much alcohol do you drink? _____
How much coffee, tea, or colas do you drink daily?_____
_____
Do you exercise? _____
How many children do you have? _____
_____

Review of Systems

Have you ever had any of the following? (circle yes or no. If yes, please describe):

Yes No a stroke or a small stroke? _____
Yes No frequent or severe headaches? _____
Yes No spells of weakness of an arm or leg? _____
Yes No ringing in the ears? _____
Yes No a seizure (convulsion)? _____
Yes No difficulty with speech? _____
Yes No loss of vision or double vision? _____
Yes No anemia? _____
Yes No problems with lungs, including wheezing or asthma? _____
Yes No problems with liver? _____
Yes No problems with thyroid? _____
Yes No problems with kidneys? _____
Yes No cancer? _____
Yes No easy bleeding or bruising? _____
Yes No difficulty swallowing? _____
Yes No hoarseness? _____
Yes No history of ulcers? _____
Yes No history of a hiatal hernia? _____
Yes No blood in stools or black/tarry stools? _____
Yes No diarrhea or constipation? _____
Yes No a recent weight loss or weight gain? _____
Yes No recent fever or chills? _____
Yes No trouble starting to urinate? _____
Yes No blood in urine? _____
Yes No kidney stones? _____
Yes No get up frequently at night to urinate? _____
Yes No snoring loudly at night? _____
Yes No blood clots in lungs, legs, or elsewhere? _____
Yes No varicose veins? _____

MCVS
MARYLAND
CARDIOVASCULAR
SPECIALISTS

Review of Systems

Have you ever had any of the following? (circle yes or no. If yes, please describe):

Yes	No	arthritis? _____
Yes	No	depression? _____
Yes	No	anxiety? _____
Yes	No	other psychiatric condition? _____
Yes	No	loss of sexual activity? _____
Yes	No	have you ever been subjected to any type of abuse (e.g. physical, sexual, or emotional? _____
Yes	No	have you ever been through any traumas? _____
Yes	No	do you feel safe in your home? _____

Is there any other important information that you wish to share with your cardiologist?

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

Reviewed by: _____ Date: _____
Physician Signature