CLEARWATER CARDIOVASCULAR CONSULTANTS

New Patient Questionnaire

Important Information for Our Patients

Enclosed are several pages of questions relating to your medical history and your health.

Please:

- Read these questions carefully.
- Answer them as completely as you can.
- ANSWER ALL OF THE QUESTIONS.
- If any of them are not applicable, write NA.
- If you do not remember exact dates, approximate them (e.g., 1950's; 1970's; about 20 years ago).
- Bring the completed forms to your appointment.

We ask all new patients to complete this information. It is just as important that you answer the "no" questions and the "yes" questions because we then know that we do not have to spend a lot of time on these questions and can concentrate on areas that are important.

It will take you approximately 15 to 30 minutes to complete this information, depending on the complexity of your medical history.

We make every effort to provide you with a thorough cardiovascular evaluation and this information will greatly help us do so. Often, knowledge of all of your medical problems is necessary for us to make appropriate recommendations and decisions.

PLEASE BRING YOUR MEDICATIONS OR A COMPLETE LIST OF YOUR MEDICATIONS INCLUDING NAMES OF DRUGS, DOSAGES, AND THE FREQUENCY THAT YOU TAKE THEM WITH YOU WHEN YOU COME FOR YOUR APPOINTMENT.

Thank you. We look forward to serving you.

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CLEARWATER CARDIOVASCULAR AND INTERVENTIONAL CONSULTANTS
CARDIOVASCULAR HISTORY FORM

Name _____ Date: _____

Have you ever been told you have heart disease?	Yes [ ] No [ ]
Have you ever been hospitalized because of a heart problem?	Yes [ ] No [ ]
Have you had any of the following problems:	
1. Heart attack?	Yes [ ] No [ ]
2. Valvular heart disease?	Yes [ ] No [ ]
3. Pain or discomfort in chest, arms, throat, jaw or upper back?	Yes [ ] No [ ]
4. Congestive Heart Failure?	Yes [ ] No [ ]
a. Shortness of breath with mild exertion?	Yes [ ] No [ ]
b. Awaken at night because of shortness of breath?	Yes [ ] No [ ]
c. Swelling of ankles or feet?	Yes [ ] No [ ]
5. High blood pressure (Hypertension)?	Yes [ ] No [ ]
6. Rheumatic Fever or Rheumatic Heart Disease?	Yes [ ] No [ ]
7. Infection in the heart (SBE or infectious endocarditis)?	Yes [ ] No [ ]
8. Pericarditis?	Yes [ ] No [ ]
9. Stroke?	Yes [ ] No [ ]
Transient Ischemia Attack (TIA)?	Yes [ ] No [ ]
10. Palpitations, skips, irregular or abnormal heart rhythms?	Yes [ ] No [ ]
11. Blackouts or fainting spells?	Yes [ ] No [ ]
12. Frequent dizzy spells or light-headedness?	Yes [ ] No [ ]
13. Pains or cramps in legs (especially in calves): ☐ While walking? ☐ In bed at night?	Yes [ ] No [ ]
14. History of Phlebitis or blood clots in veins of legs?	Yes [ ] No [ ]
15. History of blood clots in lungs (Pulmonary Embolus)?	Yes [ ] No [ ]
16. History of a heart murmur?	Yes [ ] No [ ]
17. History of abnormal EKG (Electrocardiogram)?	Yes [ ] No [ ]
18. History of abnormal chest x-ray?	Yes [ ] No [ ]

Have you ever had the following tests:

1. Stress test (Treadmill, etc.)?	Yes [ ] No [ ]
2. Echocardiogram?	Yes [ ] No [ ]
3. Holter monitor?	Yes [ ] No [ ]
4. Heart catheterization?	Yes [ ] No [ ]
5. Electrophysiologic Study (EPS)?	Yes [ ] No [ ]

Have you ever had the following:

1.	Coronary angioplasty, atherectomy or stenting?	Yes [ ]	No [ ]
2.	Angioplasty or stenting in blood vessels other than your heart (e.g. legs)?	Yes [ ]	No [ ]
3.	Heart surgery?	Yes [ ]	No [ ]
4.	Surgery on arteries other than in the heart (e.g. neck, aorta, legs, etc.?)	Yes [ ]	No [ ]
5.	Varicose vein surgery?	Yes [ ]	No [ ]
6.	A pacemaker?	Yes [ ]	No [ ]
7.	An automatic implantible defibrillator (AICD)?	Yes [ ]	No [ ]

CLEARWATER CARDIOVASCULAR AND INTERVENTIONAL CONSULTANTS
INFORMATION FOR YOUR PHYSICIAN

Name:_____ Personal Physician _____

Date: _____

CURRENT MEDICATIONS. List all **NAMES, DOSAGES AND FREQUENCY** ☐ None
(including aspirin, vitamins, antacids, eye drops, laxatives, etc.)

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

Do you have **ALLERGIES TO IODINE**, seafood or radiographic contrast dye? Yes [ ] No [ ]

Do you have **ALLERGIES** or sensitivities to medications or other substances? Yes [ ] No [ ]
If so, list drug(s) and describe the reaction:

_____
_____

***PAST MEDICAL HISTORY*:**
Have you had serious **INJURIES, BROKEN BONES**, etc.? Yes [ ] No [ ]

If so, list details and dates:

_____
_____

PREVIOUS OPERATIONS: Yes [ ] No [ ]

If so, check type of surgery and provide dates:

☐ Gall bladder_____ ☐ Appendix_____ ☐ Congenital heart surgery_____
☐ Hernia_____ ☐ Tonsils _____ ☐ Carotid surgery_____
☐ Hysterectomy_____ ☐ Coronary bypass_____ ☐ Aneurysm surgery_____
☐ Prostate_____ ☐ Valvular Heart surgery_____ ☐ Other blood vessel surgery_____
☐ Sterilization procedure_____ ☐ Other_____

_____
_____

Did you have any unusual or serious **CHILDHOOD ILLNESSES**? Yes [ ] No [ ]
If so, explain:

_____

Have you had a **BLOOD TRANSFUSION?** Yes [ ] No [ ]

List any other illnesses not requiring an operation for which you have been hospitalized: ☐ None

_____

_____

Have you used **CORTISONE-TYPE DRUGS** in the past 6 months? Yes [ ] No [ ]

For Females Only:

Last menstrual period: _____

Have you used oral contraceptives in the past year? Yes [ ] No [ ]

FAMILY HISTORY:

	Living	Age or age at death	Present health or cause of death
Father	Yes_____ No_____	_____	_____
Mother	Yes_____ No_____	_____	_____
Spouse	Yes_____ No_____	_____	_____
Brothers	No. living _____	Health_____	
	No. dead_____	Cause of death_____	
Sisters	No. living _____	Health_____	
	No. dead_____	Cause of death_____	
Children living_____		Ages and health_____	
Children dead_____		Ages and cause_____	

PLEASE CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR *BLOOD RELATIVES*:

Diabetes Stroke High blood pressure Nervous illness Cancer

Heart disease Bleeding tendency Kidney disease Tuberculosis

SOCIAL HISTORY:

Date of Birth: _____ Place of Birth: _____

Religion: ☐ _____ ☐ No Preference

Education (highest level attained) _____

Occupation: _____ ☐ Retired

Married: ☐ Yes ☐ No

Do you use tobacco now? Yes [ ] No [ ]

Did you use tobacco in the past? Yes [ ] No [ ]

____ packs per day for _____ years ☐ Stopped When: _____

Do you use alcoholic beverages? Yes [ ] No [ ]

_____

CLEARWATER CARDIOVASCULAR AND INTERVENTIONAL CONSULTANTS
REVIEW OF SYSTEMS

Name _____ **Date** _____

HEENT

1.	Do you wear corrective lenses?			Yes [ ] No [ ]
2.	Do you have glaucoma?			Yes [ ] No [ ]
3.	Do you have cataracts?			Yes [ ] No [ ]
4.	Do you have visual disturbances?			Yes [ ] No [ ]
5.	Do you have a hearing problem?			Yes [ ] No [ ]
6.	Do you wear a hearing aid?	☐ Right	☐ Left	Yes [ ] No [ ]
7.	Do you have sinus problems?	☐ Seasonal	☐ Chronic	Yes [ ] No [ ]
8.	Do you wear dentures?	☐ Full	☐ Partials	Yes [ ] No [ ]
9.	Do you have nose, mouth or throat problems?			Yes [ ] No [ ]

NEUROPSYCHIATRIC

1.	Have you had a significant head injury?	Yes [ ] No [ ]
2.	Have you had a seizure or convulsion?	Yes [ ] No [ ]
3.	Have you had a stroke or TIA?	Yes [ ] No [ ]
4.	Have you had muscle weakness?	Yes [ ] No [ ]
5.	Have you ever been paralyzed?	Yes [ ] No [ ]
6.	Do you have headaches?	Yes [ ] No [ ]
7.	Have you ever had a psychiatric illness?	Yes [ ] No [ ]

PULMONARY

1.	Have you ever had pneumonia?	Yes [ ] No [ ]
2.	Have you ever had bronchitis?	Yes [ ] No [ ]
3.	Have you ever had asthma?	Yes [ ] No [ ]
4.	Have you ever had tuberculosis?	Yes [ ] No [ ]
5.	Have you ever had a blood clot in the lung (pulmonary embolus)?	Yes [ ] No [ ]
6.	Do you have a chronic cough?	Yes [ ] No [ ]
7.	Do you regularly produce phlegm or sputum?	Yes [ ] No [ ]
8.	Have you ever coughed up blood?	Yes [ ] No [ ]
9.	Have you ever had an abnormal chest x-ray?	Yes [ ] No [ ]
10.	Do you easily get short of breath?	Yes [ ] No [ ]

GASTROINTESTINAL

1.	Have you ever had an ulcer?	Yes [ ] No [ ]
2.	Do you have frequent indigestion or heart burn?	Yes [ ] No [ ]
3.	Do you have difficulty swallowing?	Yes [ ] No [ ]
4.	Have you ever vomited blood?	Yes [ ] No [ ]
5.	Have you ever passed blood from the rectum?	Yes [ ] No [ ]
6.	Do you have frequent nausea or vomiting?	Yes [ ] No [ ]
7.	Do you have frequent diarrhea?	Yes [ ] No [ ]

8.	Do you have constipation?	Yes [ ] No [ ]
9.	Any recent change in bowel habits?	Yes [ ] No [ ]
10.	Have you ever had yellow jaundice?	Yes [ ] No [ ]
11.	Have you ever had hepatitis or liver disease?	Yes [ ] No [ ]
12.	Have you ever had gallbladder trouble?	Yes [ ] No [ ]
13.	Have you ever had problems with your pancreas?	Yes [ ] No [ ]
14.	Do you have abdominal pain?	Yes [ ] No [ ]
15.	Is your appetite normal?	Yes [ ] No [ ]
16.	Has your weight significantly changed in the past year?	Yes [ ] No [ ]

GENITOURINARY

1.	Have you ever had kidney stones?	Yes [ ] No [ ]
2.	Have you ever had an infection in your: ☐ kidneys, ☐ bladder, ☐ prostate or ☐ female organs?	Yes [ ] No [ ]
3.	Do you have any difficulty urinating?	Yes [ ] No [ ]
4.	Do you ever lose your urine when you do not mean to (incontinence)?	Yes [ ] No [ ]
5.	Have you noticed blood in your urine?	Yes [ ] No [ ]
6.	Have you had increased frequency of urination?	Yes [ ] No [ ]
7.	Do you have any history of kidney disease?	Yes [ ] No [ ]
8.	Do you have any difficulty with sexual function?	Yes [ ] No [ ]
9.	Have you had a sexually transmitted disease?	Yes [ ] No [ ]
10.	Do you have any history of abnormal vaginal discharge or bleeding (women)?	Yes [ ] No [ ]
11.	Have you had a pelvic examination or Pap smear within the past year (women)? ☐ Normal ☐ Abnormal	Yes [ ] No [ ]

MUSCULOSKELETAL

1.	Do you have joint pain?	Yes [ ] No [ ]
2.	Do you have back pain?	Yes [ ] No [ ]
3.	Do you have a history of arthritis?	Yes [ ] No [ ]
4.	Do you have swelling in your joints?	Yes [ ] No [ ]
5.	Do you have muscle pain, tenderness or swelling?	Yes [ ] No [ ]

METABOLIC

1.	Do you have diabetes?	Yes [ ] No [ ]
2.	Have you ever had thyroid problems?	Yes [ ] No [ ]
3.	Have you ever had gout?	Yes [ ] No [ ]
4.	Have you ever had elevated cholesterol or triglyceride levels?	Yes [ ] No [ ]

HEMATOLOGIC

1.	Have you ever been anemic?	Yes [ ] No [ ]
2.	Do you have a history of a bleeding disorder?	Yes [ ] No [ ]

SKIN

1.	Do you have skin problems?	Yes [ ] No [ ]

GENERAL

1.	Have you ever had cancer?	Type:_____	Yes [ ] No [ ]
2.	Have you had recent fever or chills?		Yes [ ] No [ ]
3.	Have you had breast disease?		Yes [ ] No [ ]
4.	Do you have AIDS or are you HIV positive?		Yes [ ] No [ ]