

PATIENT QUESTIONNAIRE

Patient Name	List any illness that you are being treated for	
Date of Birth	currently or in the past:	
Date:	1.	
Referred by:	2.	
	3.	
Why are you here to see a cardiologist (heart doctor)?	4.	
	5.	
	List any operations or surgeries:	
Have you ever seen another cardiologist?	1.	
If yes, Dr.	2.	
When? Where?	3.	
Check off any heart problems or symptoms:	4.	
Heart attack	5.	
Angina	Please list any allergies to medications:	
High blood pressure	(medicine and reaction)	
Heart murmur	1.	
Abnormal rhythm (arrhythmia)	2.	
Palpitation/irregular heart beats	3.	
Fainting	4.	
Enlarged heart	5.	
Chest pain or pressure	Please tell us about your medicines, including over the	
Shortness of breath	counter medications. Include name, dose or strength,	
Dizziness	and how many times a day.	
Swollen legs	1.	
Heart failure	2.	
Blue lips or fingernails	3.	
Leg cramps when you walk	4.	
Have you had:	5.	
Stress test	6.	
Echocardiogram	7.	
Cardiac catheterization/heart catheterization	8.	
Coronary angioplasty (balloon/atherectomy/stent)	9.	
Coronary bypass surgery	10.	
Valve surgery	11.	
Electrophysiology study or procedure	12.	
Pacemaker or Defibrillator	13.	
Tell us about your risk of heart disease	14.	
Please check if you have:	15.	
High blood pressure	Please check any symptoms that you have:	
High cholesterol	Lack of energy, daytime sleepiness, trouble sleeping,	
Ever smoked	loss of appetite, weight changes, fevers	
Diabetes	Eye problems such as double or blurred vision, glaucoma, cataracts	
Do you exercise (including walking)?	Hearing problems, buzzing or ringing in ears	
yes no	Stomach problems, heartburn, indigestion, change in bowel habits	
Women, have you passed menopause (change of life)?	Joint pains, swelling or redness, arthritis, back pain	
yes no	Muscle aches or tenderness, gout	
Please tell us anything else about your heart.	Paralysis (even temporary), stroke, numbness, loss of balance	
Check if any close family members have any of	Seizures, loss of memory, headaches	
the following (parents, brothers, sisters):	Thyroid disorder, diabetes, excess thirst, hunger, urination	
Heart problems	Bleeding, easy bruising, risk factors for HIV/AIDS, anemia, cancer	
High blood pressure	Health Habits:	
Diabetes	Do you smoke?	
Cancer	How many packs per day?	
Are there any other health problems in	For how many years?	
your family?	How much alcohol do you drink?	
Marital status:	Do you use recreational drugs?	
Occupation	List:	
Education Level	Religious Preference:	