RETURN PATIENT QUESTIONNAIRE

	Patient Name		Have you been seen in the hospital since your last visit?
	Date of Birth		
	Date:		
	Why are you here to see a cardiologist (heart doctor)?		
			Please tell us about your medicines, including over the
			counter medications. Include name, dose or strength,
	Check off any heart problems or symptoms since last visit:		and how many times a day.
	Heart attack		1.
	Angina		2.
	High blood pressure		3.
	Heart murmur		4.
	Abnormal rhythm (arrhythmia)		5.
	Palpitation/irregular heart beats		6.
	Fainting		7.
	Enlarged heart		8.
	Chest pain or pressure		9.
	Shortness of breath		10.
	Dizziness		11.
	Swollen legs		12.
	Heart failure		13.
	Blue lips or fingernails		14.
	Leg cramps when you walk		15.