PROVIDENCE Medical Group

Providence Medical Group Cardiology

Patient History Questionnaire

Today's Date: _____/_____/_____

_____ _____/_____/_____ _____ _____

Patient's Name DOB Age Referring Doctor

How did you hear about our practice? ☐ referring doctor ☐ friend ☐ internet/website ☐ other_____

Why are you here to see a cardiologist?_____

_____

Please check **(√)** the box if **YOU HAVE HAD** or **CURRENTLY HAVE** any of the following:

CARDIOVASCULAR SYSTEM
- ☐Angina/Chest Pain/Chest Discomfort
- ☐Arrhythmia/Palpitations/Irregular pulse
- ☐ Dizziness
- ☐Enlarged Heart
- ☐ Fainting/Near Fainting
- ☐Heart Attack
- ☐ Congestive Heart Failure
- ☐Heart Murmur
- ☐ High Blood Pressure/Low Blood Pressure
- ☐ High Cholesterol
- ☐Rheumatic Fever
- ☐ Swollen Legs/Edema
- ☐Leg Cramps with Exertion
- ☐ Erectile Dysfunction
- ☐Vascular Disease
  - ☐Abdominal Aortic Aneurysm
  - ☐Lower Extremity/PVD
  - ☐ Carotid Artery Disease

HEMATOLOGICAL/ONCOLOGICAL
- ☐Cancer-Type: _____
- ☐Anemia
- ☐ Bleeding Disorder
- ☐ Thrombophilia/Clotting Disorder
- ☐ Blood Clots in Legs or Lungs

ALLERGIES/IMMUNOLOGY
- ☐ Seasonal Allergies
- ☐Food Allergies
- ☐ Hives

RESPIRATORY SYSTEM
- ☐Asthma/COPD/Bronchitis
- ☐ Cough
- ☐Pneumonia
- ☐Shortness of Breath
- ☐Obstructive Sleep Apnea

RENAL/UROLOGICAL
- ☐Kidney Disease
- ☐Blood in Urine
- ☐Kidney Stone
- ☐Painful Urination
- ☐Prostate Enlarged

RHEUMATOLOGIC
- ☐Gout
- ☐ Arthritis/Joint Swelling
- ☐Muscle Aches
- ☐Connective Tissue Disease

INFECTIOUS DISEASE
- ☐ Hepatitis
- ☐HIV/AIDS

NEUROLOGICAL
- ☐Neuropathy
- ☐ Vision Loss
- ☐Hearing Loss
- ☐ Stroke/TIA
- ☐Seizure

ENDOCRINE SYSTEM
- ☐Diabetes
- ☐ Fever or Night Sweats
- ☐ Thyroid Disease
- ☐ Weight Gain/Loss

GASTROINTESTINAL SYSTEM
- ☐Gastrointestinal Bleeding
- ☐ Blood in Stool
- ☐ Gall Stone
- ☐Hiatal Hernia
- ☐ Reflux/Heartburn
- ☐Ulcers
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Nausea or Vomiting

PSYCHOLOGICAL
- ☐Anxiety/Panic Attacks
- ☐Depression
- ☐Insomnia
- ☐Other Psychotic Disorder

HAVE YOU EVER HAD:
- ☐ECG/EKG
- ☐Stress Test
- ☐ Echocardiogram
- ☐ Heart Catheterization
- ☐ Coronary Angioplasty/Stent
- ☐Coronary Bypass Surgery
- ☐Valve Surgery
- ☐ Pacemaker or Defibrillator
- ☐ Electrophysiology Study/Procedure
- ☐ Cardiac CT or Calcium Score

~ OVER ~

Who do you **LIVE WITH?**: _____ ☐ Married ☐ Single ☐ Partner ☐ Divorced
OCCUPATION/TYPE OF WORK: _____
Ever **SMOKED?**: NO ☐ YES ☐ If yes, how many years _____, _____ packs per day? When did you quit? _____
Do you **DRINK ALCOHOL?**: NO ☐ YES ☐ If yes, how much? _____
Do you use **RECREATIONAL DRUGS?** (i.e.: cocaine, marijuana, heroin, etc) NO ☐ YES ☐ If yes, what kind? _____
Do you **DRINK CAFFEINE?**: NO ☐ YES ☐ If yes, how much _____
Do you **EXERCISE?**: NO ☐ YES ☐ If yes, how often _____, what kind _____ and where _____

List **FAMILY HEALTH PROBLEMS** such as: Hypertension, Diabetes, Coronary Artery Disease, Stent, CABG, Valve Surgery Hyperlipidemia, AAA, CHF, Cardiomyopathy, Arrhythmias, Unexplained or Sudden Death, Congenital Heart Disease, etc.

	Age(s)	**Alive or Deceased**	**Problems**
Father			
Mother			
Brother(s)			
Sister(s)			
Other			

Please List ALL Medical Problems, Operations and Injuries You CURRENTLY HAVE or HAVE HAD IN THE PAST

_____
_____
_____
_____
_____
_____

Are you **ALLERGIC TO IODINE or Contrast Dye?**: NO ☐ YES ☐ _____
Are you **ALLERGIC TO ANY MEDICATIONS?**: NO ☐ YES ☐
If yes, please list medication name and the reactions

_____
_____
_____
_____
_____

Please list all medicines you are **currently taking**. Include over-the-counter medicines as well as prescription drugs.

Name	Dose/Strength	Frequency	Name	Dose/Strength	Frequency

FOR OFFICE USE ONLY

HT:_____

WT:_____

BP R:_____

BP L:_____

PULSE: _____