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Interventional Cardiology

MEDICAL HISTORY QUESTIONNAIRE

Today's date: _____ Date of birth: _____
Name: _____ Age: _____
Referring physician: _____ Primary care physician: _____
Other physicians involved in your care: _____
Present concern: _____
_____

Cardiovascular history: (check box/provide details):

- ☐ Prior myocardial infarction/heart attack date: _____
- ☐ Prior coronary bypass surgery date: _____
- ☐ Prior coronary intervention/angioplasty/stent date: _____
- ☐ Heart valve disease/prior valve surgery date: _____
- ☐ Congestive heart failure: _____
- ☐ Diabetes: _____
- ☐ Dyslipidemia/high cholesterol: _____
- ☐ Current/prior tobacco use: _____
- ☐ Family history of heart disease: _____
- ☐ Pacemaker/defibrillator date: _____
- ☐ Peripheral artery disease/aneurysm/vascular surgery: _____
- ☐ Prior stroke: _____
- ☐ Lung disease/COPD/emphysema: _____
- ☐ Kidney disease/current or prior dialysis: _____

Other surgeries/date:

_____ _____
_____ _____
_____ _____

Prescription medications (drug name/dose/frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Over-the-counter medications and supplements (aspirin, pain relievers, antihistamines, etc.):

_____
_____
_____

Allergies and intolerances (list reactions):

- ☐ Penicillin _____
- ☐ Aspirin _____
- ☐ Narcotics _____
- ☐ Anesthetics _____
- ☐ Sulfa _____
- ☐ Sedatives _____
- ☐ X-ray contrast _____
- ☐ Other _____

Habits:

- ☐ Tobacco Type: _____
- ☐ Began: _____
- ☐ Quit: _____
- ☐ Alcohol -- drinks per week: _____
- ☐ Caffeine -- beverages per day: _____

Family History:

- ☐ Heart disease: Relative (s) _____
- ☐ Hypertension : Relative (s) _____
- ☐ Diabetes: Relative (s) _____
- ☐ High cholesterol: Relative (s) _____

Father	Age _____	Alive /deceased	Cause of death _____
Mother	Age _____	Alive /deceased	Cause of death _____
Brother	Age _____	Alive /deceased	Cause of death _____
Brother	Age _____	Alive /deceased	Cause of death _____
Brother	Age _____	Alive /deceased	Cause of death _____
Sister	Age _____	Alive /deceased	Cause of death _____
Sister	Age _____	Alive /deceased	Cause of death _____
Sister	Age _____	Alive /deceased	Cause of death _____
Sister	Age _____	Alive /deceased	Cause of death _____
Child	Age _____	Alive /deceased	Cause of death _____
Child	Age _____	Alive /deceased	Cause of death _____
Child	Age _____	Alive /deceased	Cause of death _____

Social History:

Occupation / Current: _____ Prior: _____
Marital Status: _____
Relatives living with you: _____

Exercise:

Types: _____
Hours per Week: _____

REVIEW OF SYSTEMS:
(Circle Symptoms)

Cardiac

- Chest discomfort
- Irregular / rapid heart beat
- Fainting / blackouts
- Shortness of breath
- Breathing problems at night
- Ankle swelling
- Palpitations
- Passing out
- Lightheadedness

Vascular

- Leg or arm pain with exertion
- Varicose vein surgery
- Hand pain with cold exposure
- Prior artery surgery
- Artery or vein clotting
- Artery or vein stent

Respiratory

- Shortness of breath
- Wheezing
- Nosebleeds
- Emphysema / COPD
- Cough
- Sleep trouble / apnea /snoring
- Asthma
- Coughing-up blood
- Excessive sleepiness

Gastrointestinal

- Abdominal pain
- Heartburn / reflux / GERD
- Diarrhea
- Gallstones
- Unexplained weight loss
- Ulcer
- Constipation
- Hepatitis / jaundice
- Loss of Appetite
- Nausea or vomiting
- Vomiting blood
- Rectal bleeding

Genitourinary

- Frequent urination
- Blood in urine
- Kidney stones
- Nighttime urination
- Weak urine stream
- Prostate problems
- Painful urination
- Vaginal bleeding
- Erectile dysfunction.

Neurologic

- Seizures / convulsions
- Imbalance / falling
- Hearing problems
- Memory difficulty
- Alzheimer's
- Numbness / tingling
- Dizziness / vertigo
- Visual problems
- Anxiety
- Parkinson's
- Tremor
- Headaches
- Loss of smell
- Depression

Endocrine

- Heat / cold intolerance
- Dry skin
- Hair loss
- Flushing / sweating
- Voice changes
- Weight change over 10 pounds
- Irregular menstrual periods
- Unexplained fever
- Night sweats

Skin /Blood /Musculoskeletal

- Arthritis
- Muscle aches
- Mouth / oral ulcers
- Muscle weakness
- Rash
- Easy bruising / bleeding

Patient Signature: _____ Date: _____