

# Cardiovascular Consultants of Carroll County

## New Patient Questionnaire

Name: \_\_\_\_\_ Your Family Physician: \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Account: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Why are you seeing us today?

### Have you ever had any of the following (yes or no), please provide description if yes:

Yes No A heart attack? \_\_\_\_\_

Yes No Angina? \_\_\_\_\_

Yes No Stroke or Mini-Stroke? \_\_\_\_\_

Yes No Congestive Heart Failure? \_\_\_\_\_

Yes No Rheumatic Fever? \_\_\_\_\_

Yes No Heart Murmur? \_\_\_\_\_

Yes No Chest pain or pressure? \_\_\_\_\_

Yes No Shortness of breath? \_\_\_\_\_

Yes No Bouts of shortness of breath at night? \_\_\_\_\_

Yes No Palpitations, irregular heart beats, fast or slow heart rates? \_\_\_\_\_

Yes No Lightheadedness or dizzy spells? \_\_\_\_\_

Yes No Have you fainted or lost consciousness in last three years? \_\_\_\_\_

Yes No Leg swelling? \_\_\_\_\_

Yes No Blue lips or fingernails? \_\_\_\_\_

Yes No Leg/hip/buttock pain or cramps when you walk? \_\_\_\_\_

**Past Medical History:**

**Please circle all conditions for which you are currently being treated or have ongoing follow up:**

- |                               |                           |
|-------------------------------|---------------------------|
| Acid Reflux/Heartburn         | Erectile Dysfunction      |
| Asthma/Emphysema/COPD         | Gout                      |
| Cancer                        | Hepatitis                 |
| Coronary Artery Disease(CAD)  | High Cholesterol          |
| Congestive Heart Failure(CHF) | High Blood Pressure       |
| Kidney Disease                | Migraines                 |
| Deep Vein Thrombosis(DVT)     | Peripheral Artery Disease |
| Depression                    | Reflux or Acid            |
| Diabetes                      | Stomach Ulcers            |
| Drug Addiction                | Other_____                |

**Have you had any of the following procedures? IF YES, please provide date(s):**

- Echocardiogram (heart sonogram): \_\_\_\_\_
- Pacemaker/Defibrillator Placement: \_\_\_\_\_
- Stress Test: \_\_\_\_\_
- Heart Catheterization, Angioplasty, or Stent Placement \_\_\_\_\_
- Heart Bypass or Valve Surgery: \_\_\_\_\_

**Hospitalizations and Surgeries, Why? (please write at which hospital or facility):**

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**Medications: (please list name, strength, and how often you take them, or attach a list)**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Please list medication allergies:**

\_\_\_\_\_

\_\_\_\_\_

- Yes No Allergic to X-ray contrast dye?
- Yes No Allergic to iodine?
- Yes No Allergic to shellfish?

**Family History:**

Any family member(s) with a heart attack, angina, heart failure, sudden death, diabetes, high blood pressure or stroke?

Yes No

If Yes(circle): Mother Father Sibling

**Social History:**

Occupation: \_\_\_\_\_ Where? \_\_\_\_\_

Education level \_\_\_\_\_

Marital Status(please circle): Single? Married? Divorced? Widowed?

How many children? \_\_\_\_\_

Yes No History or currently smoke/chew tobacco? If yes, \_\_\_\_\_ packs/day for \_\_\_\_\_/years.

Yes No Consume alcohol? If yes, how many servings? \_\_\_\_\_/day \_\_\_\_\_/week

Yes No Do you use any illicit drugs? \_\_\_\_\_

Yes No Do you use any ambulatory devices(cane, walker, wheelchair)? \_\_\_\_\_

Yes No Do you exercise? If yes, how often per week? \_\_\_\_\_

All together, how many servings of coffee, tea, ice tea or colas per day? \_\_\_\_\_

**Review of Systems:**

Have you ever had any of the following? Yes or no, if yes, please describe):

- Yes No Recent fever or chills? \_\_\_\_\_
- Yes No Recent weight loss or weight gain? \_\_\_\_\_
- Yes No Seizure or convulsion? \_\_\_\_\_
- Yes No Severe or frequent headaches? \_\_\_\_\_
- Yes No Weakness in arms or Legs? \_\_\_\_\_
- Yes No Loss of vision or double vision? \_\_\_\_\_
- Yes No Difficulty with speech? \_\_\_\_\_
- Yes No Ringing in the ears? \_\_\_\_\_
- Yes No Difficulty swallowing food? \_\_\_\_\_
- Yes No Thyroid abnormality? \_\_\_\_\_
- Yes No Carotid artery blockage/surgery? \_\_\_\_\_
- Yes No Coughing up blood? \_\_\_\_\_
- Yes No Pneumonia? \_\_\_\_\_
- Yes No Tuberculosis? \_\_\_\_\_
- Yes No Asthma or lung problems? \_\_\_\_\_
- Yes No Snoring or apnea? \_\_\_\_\_
- Yes No Stomach/Peptic ulcers or bleeding ulcers? \_\_\_\_\_
- Yes No A history or hiatal hernia? \_\_\_\_\_
- Yes No Blood in stools or black/tarry stools? \_\_\_\_\_
- Yes No Diarrhea or constipation? \_\_\_\_\_
- Yes No Hepatitis or cirrhosis of liver? \_\_\_\_\_
- Yes No Problems with liver? \_\_\_\_\_
- Yes No Kidney stones? \_\_\_\_\_
- Yes No Kidney failure? \_\_\_\_\_
- Yes No Frequent urination at night? \_\_\_\_\_
- Yes No Blood in urine? \_\_\_\_\_
- Yes No Trouble starting to urinate? \_\_\_\_\_
- Yes No Blood transfusion? \_\_\_\_\_
- Yes No Anemia? \_\_\_\_\_
- Yes No Cancer? \_\_\_\_\_
- Yes No Easy bleeding or bruising? \_\_\_\_\_
- Yes No Blood clots in your legs or lungs? \_\_\_\_\_
- Yes No Varicose veins? \_\_\_\_\_
- Yes No Arthritis? \_\_\_\_\_
- Yes No Depression or a psychiatric condition? \_\_\_\_\_
- Yes No Loss of sexual activity? \_\_\_\_\_
- Yes No Rheumatic Fever? \_\_\_\_\_

Office Section Only

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ L)BP \_\_\_\_\_ / \_\_\_\_\_

Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Pain \_\_\_\_\_ R)BP \_\_\_\_\_ / \_\_\_\_\_

DOCTOR'S SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_