WOODHOLME
CARDIOVASCULAR ASSOCIATES

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NEW PATIENT QUESTIONAIRE

Today's Date_____

Name_____ **Age**_____ **Birth Date**_____

Home Phone #_____ **Cell #**_____

E-mail Address _____

Primary Doctor _____ **Phone #**_____

Referred By □ **Dr.**_____ □ **Friend**_____

Reason you are seeing a Cardiologist (Check all that apply)

□ **Chest pain/discomfort – describe type of discomfort, how long it lasts, location, and what makes it better or worse**_____

_____

_____

□ **Abnormal EKG** □ **Abnormal stress test**
□ **Dizziness** □ **Passing out**
□ **Pre-operative assessment**
□ **Problems breathing (If yes, →** □ **with activity/exertion** □ **at rest**
□ **Prior history of heart problems. Please specify:** _____

_____

_____

□ **Palpitations or sensation of a rapid or irregular heartbeat. Please explain:**

_____

_____

□ **Other – specify:**_____

_____

SOCIAL HISTORY

Occupation: _____
Education: _____
Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Widow/Widower** □ **Separated**
Number of Children: _____ **Ages:** _____
How much alcohol do you drink: □ **None** □ **Daily (1-2)** □ **Daily (more than 2)**
Do you smoke? □ **No** □ **Yes (** ____ **number of packs per day/** _____ **number of years)**
Did you stop smoking? □ **No** □ **Yes When?**_____
How many caffeinated beverages daily? _____

FAMILY HISTORY

Has any family member had a heart problem (or died of a heart problem)? □ **No** □ **Yes**
If yes, please explain:

_____
_____
_____

PAST SURGICAL HISTORY

If you have had a prior surgery, specify the name of the operation and when you had it:

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY (Check all that apply):

- □ **Diabetes**
- □ **Kidney disease**
- □ **Emphysema**
- □ **Anemia**
- □ **Thyroid disease**
- □ **Peripheral/vascular disease**
- □ **Hypertension (high blood pressure)**
- □ **Asthma**
- □ **Bronchitis**
- □ **Reflux/indigestion**
- □ **Pneumonia**
- □ **History of Stroke or TIA**
- □ **Cancer – what type?** _____
- □ **Other (Specify)**

_____
_____

□ **Hospitalizations in the last 2 years:**

1) **Why?** _____
   When? _____ **Where?** _____
2) **Why?** _____
   When? _____ **Where?** _____

Have you ever had an allergic reaction to X-Ray contrast dye, iodine or shellfish?
□ **No** □ **Yes - please explain:** _____
_____
_____

PAST CARDIAC HISTORY (Check all that apply):

- □ **High cholesterol**
- □ **Angina**
- □ **Arrhythmia**
- □ **Heart Attack**
- □ **Congestive Heart Failure**
- □ **Atrial Fibrillation**

- □ **Stress test** **Year** _____ **Where?** _____
- □ **Echocardiogram** **Year** _____ **Where?** _____
- □ **Catheterization** **Year** _____ **Where?** _____

Name of prior Cardiologist? _____ **When?** _____

CARDIAC PROCEDURES/SURGERIES

- □ **Angioplasty/Stent** Year_____ Where? _____
  Doctor_____
  Year_____ Where? _____
  Doctor_____
- □ **Coronary Bypass/ Valve Surgery** Year_____ Where? _____
  Doctor _____
- □ **Pacemaker** Year_____ Where? _____
  Doctor_____
- □ **Defibrillator** Year_____ Where? _____
  Doctor_____

REVIEW OF SYSTEMS (Check all that apply):

General

- □ Fever □ Chills □ Excessive Sweating
- □ Loss of appetite □ Weight Loss _____lbs. □ Weight gain _____ lbs.
- □ If none of the above, please check here

HEENT

- □ Headaches □ Ringing in ears □ Sore throat □ Dizziness □ Double vision
- □ If none of the above, please check here

Endocrine

- □ Excessive thirst □ Thyroid disorder □ If none of the above, please check here

Pulmonary

- □ Asthma □ Cough □ Shortness of breath □ Pneumonia
- □ If none of the above, please check here

Cardiac

- □ Chest or throat discomfort
- □ Palpitations
- □ Short of breath after ___ blocks or ___ flights of steps
- □ Shortness of breath at rest
- □ Passing out
- □ Swelling of legs
- □ Waking from sleep short of breath
- □ How many pillows under your head in bed? _____
- □ If none of the above, please check here

Gastrointestinal

- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Bloody/tarry stool
- □ Indigestion
- □ Constipation
- □ If none of the above, please check here

Genitourinary

- □ Burning with urination
- □ Blood in urine
- □ Urinary frequency
- □ Number of times urinating at night? _____
- □ Difficulty starting to urinate
- □ If none of the above, please check here
- □ Problems with sexual function
- □ Prostate enlargement
- □ Kidney stones

GYN

- □ Date of last menstrual period _____

Neurological

- □ Weakness
- □ Numbness
- □ Seizures
- □ If none of the above, please check here

Psychological

- □ Depression
- □ Bipolar
- □ Anxiety
- □ Psychosis
- □ If none of the above, please check here

Extremities

- □ Swelling
- □ Varicose veins
- □ Blood clots in legs
- □ Pain in legs when walking
  On how many blocks? _____
- □ If none of the above, please check here

Hematological

- □ Anemia
- □ Excessive Bruising
- □ Bleeding
- □ If none of the above, please check here

ALLERGIES

Name any drug to which you are allergic:

_____

_____

MEDICATIONS

******It is very important to specify name, dose and frequency******

NAME OF MEDICATION **DOSE/FREQUENCY (number of times per day)**

□ **Aspirin** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed By: _____ **Date:** _____

Physician Signature