Texas Health
Heart & Vascular Specialists

Date: _____

New Patient Medical Questionnaire

Patient Name: _____Date of Birth:_____Age:_____
Primary Care Physician: _____
Other Physician: _____
What physicians requested this consultation? _____
Pharmacy: _____ Location (nearest intersection) _____

CHIEF COMPLAINT

What problem(s) are you here for today?

_____
_____
_____

CORONARY RISK FACTORS: (please check if you have or have had any of the following and year it was first identified)

__Hypertension (high blood pressure)
__Diabetes – If yes are you taking pills or insulin
__Abnormal/High Cholesterol
__Peripheral Artery Disease (carotid, legs)
__Family History of heart disease
__Obstructive Sleep Apnea
__CPAP Machine
__Current Smoker or __Former Smoker

CARDIOVASCULAR HISTORY

Please check any for all that apply, and year of first diagnosis.

__Coronary Artery Disease Year: _____
__Heart Attack Year: _____
__Enlarged Heart Year: _____
__Stroke or TIA (mini stroke) Year: _____
__Heart Murmur Year: _____
__Heart Valve disease Year: _____
__Carotid Artery Disease/Stenosis Year: _____
__Pulmonary Embolism (blood clot in lung) Year:_____
__Aneurysm Year: ____
__Pacemaker Year: ____
__Defibrillator Year: ____
__Arrhythmia (Abnormal Rhythm) Year: ____
__Peripheral Artery Disease (blockages in leg arteries) Year: _____
__Congestive Heart Failure (weak heart muscle) Year: _____
__Deep Vein Thrombosis (DVT, blood clot in leg) Year: _____
__Hospitalization for any reason _____

CARDIAC PROCEDURES/DIAGNOSTIC TESTING

__ Heart Catheterization _____
__ Heart/Leg or other Angioplasty/Stent Placement _____
__Electrophysiology or Ablation Procedure _____

Texas Health
Heart & Vascular Specialists

Date: _____

CURRENT MEDICATION / SUPPLEMENT

Please list ALL medication that you are taking at home. Include ALL prescription medication, non-prescription medications, vitamins, herbal remedies, and supplements

Name of Medication/Dose/How often or when taken

Example: Lasix 40mg twice a day

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Please attach additional pages if necessary

ALLERGIES/INTOLERANCES TO MEDICATION

Please list any medication, foods, or material such as contrast dye or iodine that you are allergic to, had an adverse reaction to or do not tolerate and describe the reaction.

Medication reaction (e.g., hives, swelling, shortness of breath, rash, etc.)

Example: Lipitor-> hives, muscle aches

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY / OPERATIONS

Please list any other surgeries you have had and include the year.

Surgery	Date
Gallbladder Removed	*1998*

_____
_____
_____
_____
_____
_____

Texas Health
Heart & Vascular Specialists

Date: _____

PAST MEDICAL HISTORY

Check all that apply and indicate when it was first identified

PULMONARY:

__Asthma Year:_____ __Pneumonia Year:_____
__Emphysema / COPD Year: ____

GASTROINTESTINAL:

__Gastrointestinal Bleeding Year: ____ __ Ulcers Year:_____
__Reflux (GERD) Year: ____ __Liver Disease/Hepatitis Year: ____

RENAL/GENITOURINARY

__Kidney Disease/Elevated Creatinine Year____ __Prostate Disease Year:_____
__Dialysis Year:____

NEUROLOGICAL/PSYCHOLOGICAL

__Intracranial (in the brain) Bleeding Year:_____ __ Seizure Disorder Year:_____
__Dementia Year:_____ __Depression Year:_____
__Anxiety Disorder Year:_____ __Parkinson's Year:_____

FEMALE REPODUCTIVE: If Applicable

__Menopause (at what age?) _____ __Currently Pregnant (number of weeks) _____

ENDOCRINE

__Thyroid Disorder Year:____

OTHER

__Cancer Year:____ __HIV Year:____
__Clotting Disorder Year:____ __Autoimmune Disorder (i.e. Lupus) Year:____
__Bleeding Disorder Year:____ __ Arthritis Year:____
__Anemia Year:____

SOCIAL HISTORY

Marital Status (circle): Single Married Divorced Separated Widowed Domestic Partner
Number of children: _____ With whom do you live? _____
Are you retired: Yes No Current or Pervious Occupation:_____
Leisure Activities: _____

EXERCISE

No/Sedentary Occasional Regular Active Lifestyle Physically unable to exercise

Type of exercise and how long (how many minutes and times per week):

_____

Texas Health
Heart & Vascular Specialists

Date: _____

Do you use tobacco? Yes Formerly Never
Cigarettes/Cigars/Pips/Chewing tobacco/Electronic cigarette (Circle which one)
_____Per day Years Smoked? _____ Quit Date? _____

Do you use alcohol? Yes Formerly Never
Beer/wine/Spirits (Circle which one)
_____ servings per day/ wk / mo / yr

Do you use caffeine? Yes Formerly Never
Caffeinated Coffee/Tea/Soda? (Circle which one)
____ cups per day/ wk / mo / yr

Do you use recreational drugs? Yes Formerly Never
Marijuana/Cocaine/Methamphetamine/Heroin/other _____
Date quit? _____ Rehab? _____

Currently on any particular diet? Which one? _____

FAMILY HISTORY
Please indicate if your Father, Mother, Brother(s) or Sister(s) have had the following diagnoses and their age when it was diagnosed.

Heart Attack, Stroke, Angioplasty/Stents. Heart Surgery, Congestive Heart Failure, Blood Clots, Aneurysm, or Abnormal Heart Rhythm

	Current Age	Diagnosis (age of diagnosis)	Age of Death (if applicable and cause of death)
Father			
Mother			
Brother(s)			
Sister(s)			
Other			

__Check here if Adopted/Unknown family History

Texas Health
Heart & Vascular Specialists

Date: _____

REVIEW OF SYSTEMS

Patient Name: _____ Date of Birth: _____

Please check if you have any of the follow symptoms:

CONSTITUTION	**EYES**	**GASTROINTESTIONAL**	**ENDO/HEME/ALL**
Fever	Blurred Vison	Heartburn	Easy bruising
Chills	Double vison	Nausea	Allergies
Weight Loss	Sensitive to light	Vomiting	Excessive thirst
Fatigue	Eye pain	Abdominal pain	**NEUROLOGICAL**
Sweating/Perspiration	Eye discharge	Diarrhea	Dizziness
Weakness	Eye redness	Constipation	Tingling
SKIN	**CARDIOVASCULAR**	Blood in stool	Tremor
Rash	Chest Pain	Black stool	Sensory change
Itching	Palpitations/flutters	**GENITOURINARY**	Speech change
ENT	Shortness of breath When lying down	Painful urination	Focal weakness
Headache	Leg pain while walking	Urgency	Seizures
Hearing Loss	Leg swelling	Urinary frequency	Loss of consciousness
Ringing in the ears	Waking from sleep short of breath	Blood in urine	**PSYCHIATRIC**
Ear pain	**RESPIRATORY**	Flank pain	Depression
Ear discharge	Cough	**MUSCULOSKELETAL**	Suicidal ideas
Nosebleeds	Coughing up blood	Muscle pain	Substance abuse
Congestions	Sputum production	Neck pain	Hallucination
Sore throat	Short of breath	Back pain	Nervous/anxious
	Wheezing	Joint pain	Insomnia
		Falls	Memory loss