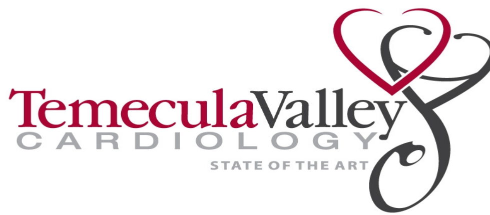

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**		
What medical problem are you here to have evaluated?			

PERSONAL HEALTH HISTORY

Please indicate if you have had any of t he following events or procedures:

Cardiovascular History		Date/Year	Hospital
Myocardial Infarction (Heart Attack)	☐Yes ☐No		
Heart Catheterization/angiogram/stents	☐Yes ☐No		
Coronary Artery Bypass Surgery	☐Yes ☐No		
Treadmill Stress Test	☐Yes ☐No		
Echocardiogram (Ultrasound of the Heart)	☐Yes ☐No		
Holter Monitor	☐Yes ☐No		
Pacemaker/Defibrillator	☐Yes ☐No		

List any medical problems that other doctors have diagnosed:

	Date Diagnosed		Date Diagnosed
☐ High Blood pressure		☐ Others	
☐ High Cholesterol			
☐ Diabetes			
☐ Cardiac Arrhythmias			
☐ Stroke			
☐ Peripheral Artery Disease			

Surgeries/ Hospitalizations

Reason	Date/Year	Hospital

List all prescriptions, non-prescriptions, vitamins, supplements, and herbal medications.

Medication	Dose	Frequency	Medication	Dose	Frequency

Name:	Date of Birth:
Allergies or sensitivities (please include IV contrast, x-ray dye, iodine, fish, and /or shellfish)	
Medication	**Reaction You Had**

CARDIAC HISTORY AND SYMPTOMS

Please check and complete the following that pertain to your history:

☐ Rheumatic Fever, what age?	☐ Rheumatic Heart disease, what age?	☐ Scarlet Fever, what age?	
☐ Heart disease at birth, what type?	☐ Heart murmur, first noted when?		
☐ Chest discomfort pain	How frequently? When?	With exercise?	At rest?
☐ Palpitations	☐ Fainting (syncope)	☐ Lightheadedness/dizzy	☐ Shortness of breath with exertion
☐ Sleeping with 2 or more pillows	☐ Shortness of breath that awakens you from sleep	☐ Snoring at night	☐ Cough
☐ Heartburn or GERD	☐ Recent weight gain or loss	☐ Fever	☐ Chills
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Sweating
☐ Previous leg vein stripping	☐ Phlebitis	☐ Swelling in the ankles	☐ Leg, buttock or foot pain with walking
☐ Ulcers or sores on you feet	☐ Difficulty with erection or ejaculation	☐ Unusual fatigue	☐ Do you feel depressed

FAMILY HEALTH HISTORY

	AGE		SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH		AGE		SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH
Father					**Children**	☐ M ☐ F			
Mother						☐ M ☐ F			
Sibling	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			

SOCIAL HISTORY

Personal	Where were you born?		Current occupation:	
	Martial status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		How many children and their ages?	
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ Yes ☐ No		If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No	
	# Of meals you eat in an average day?			
	Rank salt intake ☐ Hi ☐ Med ☐ Low		Rank fat intake ☐ Hi ☐ Med ☐ Low	
Caffeine	☐ None ☐ Tea ☐ Cola ☐ Coffee ☐ Energy Drinks		# Of cups/cans per day?	
Alcohol	Do you currently drink alcohol? ☐ Yes ☐ No		If yes how many drinks per week?	
	Are you prone to “binge” drinking? ☐ Yes ☐ No		If No, were you a heavy drinker in the past?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No	☐ If yes, # of years	☐ If No, # of years quit	
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No			

Patient Signature ____________________ Date ____________________

Physician Signature ____________________ Date ____________________