



HEALTH HISTORY QUESTIONNAIRE

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

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F		DOB:	
Previous or referring doctor:			Date of last physical exam:		
What medical problem are you here to have evaluated?					
PERSONAL HEALTH HISTORY					
<i>Please indicate if you have had any of the following events or procedures:</i>					
Cardiovascular History		Date/Year	Hospital		
Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Heart Catheterization/angiogram/stents	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Coronary Artery Bypass Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Treadmill Stress Test	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Echocardiogram (Ultrasound of the Heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Holter Monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Pacemaker/Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No				
List any medical problems that other doctors have diagnosed:					
	Date Diagnosed		Date Diagnosed		
<input type="checkbox"/> High Blood pressure		<input type="checkbox"/> Others			
<input type="checkbox"/> High Cholesterol					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Cardiac Arrhythmias					
<input type="checkbox"/> Stroke					
<input type="checkbox"/> 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:

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

FAMILY HEALTH HISTORY							
	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH		AGE	SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		

SOCIAL HISTORY

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