

CARDIOVASCULAR ASSOCIATES PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **AGE** _____

DATE: _____

Please complete the following form before your appointment with Cardiovascular Associates.

GENERAL

Who is your family physician? _____

What was the main reason you were referred to Cardiovascular Associates?

Are you currently having problems with any of the following:
(please circle answer Y=yes/N=no)

Chest discomfort (pain, pressure, tightness) with physical activity	Y	N
Shortness of breath with minimal activity or shortness of breath when lying flat	Y	N
Swelling in hands or feet	Y	N
Irregular heart beats or racing heart	Y	N
Extreme lightheadedness or passing out	Y	N
Pain in your calf or thigh muscles with walking	Y	N

PAST MEDICAL HISTORY

Have you ever been diagnosed with or have you had: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Angioplasty/stenting | <input type="checkbox"/> Valvular heart disease | <input type="checkbox"/> Congenital heart disease |
| <input type="checkbox"/> Coronary bypass surgery | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Pericarditis | <input type="checkbox"/> Aneurysm |
| | <input type="checkbox"/> Claudication | |

(Respiratory)	Cough	Excessive phlegm
	Excessive snoring	Wheezing
	Bloody phlegm	
(Abdomen)	Bloating	Change in bowel habits
	Bloody bowel movements	Nausea or vomiting
	Diarrhea	Constipation
	Abdominal pain	Heartburn
(Kidney/bladder)	Slow urine flow	Bloody urine
	Frequent urination at night	Pain with urination
(Neurologic)	Brief loss of vision	Lightheadedness
	Weakness	Frequent falls
	Numbness	
(Blood)	Easy bruising	Low blood counts (anemia)
	Easy bleeding	Phlebitis
(Endocrine)	Cold Intolerance	Heat Intolerance
	Excessive thirst	
(Musculoskeletal)	Painful joints	Muscle pain
	Swollen joints	

FEMALES ONLY:

Are you currently pregnant?	Y	N
Are you taking hormone replacement therapy?	Y	N
Did you experience premature menopause or undergo surgical menopause?	Y	N
Have you had problems with recurrent miscarriages?	Y	N

MALES ONLY:

Are you having sexual problems (i.e. inability to obtain erection)?	Y	N
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