MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

REFERRED BY: _____ TODAY'S DATE: _____

What is the main reason you are seeing the doctor today?

_____

1. Do you have or have you had in the past, any of the following conditions:

_____ Heart Attack
_____ High Blood Pressure
_____ Diabetes Mellitus
_____ Stroke
_____ High Cholesterol
_____ High Triglycerides
_____ Blocked Arteries
_____ Cancer (any kind)
_____ Ulcers
_____ Kidney or Bladder/Prostate Problems
_____ Rheumatic Fever/Rheumatic Heart Disease
_____ Lung Disease (Asthma/Bronchitis/Emphysema/Other)
_____ Peripheral Vascular Disease (leg pain while walking or leg numbness)

2. Do you have now or have you had in the past, any other significant medical illnesses? Please describe briefly and give approximate dates. (Include allergies, anemia,arthritis,bleeding problems, epilepsy, gallbladder disease, glaucoma, gout, mental problems, migraine headaches, TB)

_____
_____
_____

3. Please list any Cardiovascular Surgeries you have had. Also state (if known) the approximate date of surgery, the name of the physician or surgeon and name of the hospital where performed.

_____
_____
_____

4. Please list any other surgeries you have had at any time:

_____
_____
_____

5. List any significant accidents or injuries which required medical treatment

_____
_____
_____

6. MEDICATIONS:
Please list all prescription medications which you take regularly.

Medication	Dose	Directions

Please list any over –the- counter medications that you take regularly including vitamins or supplements.

Medication	Dose	Directions

7. Social History (Circle Yes or No)
   A. Do you smoke? Yes or No Did you previously smoke? Yes or No
      If yes, how much (#packs/day)? _____
   B. Any use of smokeless tobacco? Yes or No
      If yes, how much? _____
   C. Do you use alcoholic beverages? Yes or No
      If yes, what is your typical intake? (#beers/week, oz. per day)
      _____

   D. What is your usual occupation? _____

8. Family History Please list each family member, state whether living or deceased. List age at time of death (if deceased). List known illnesses and or/cause of death.

Family Member	(Circle one)	Age	Illness/Cause of Death
Mother	Living/Deceased	_____	_____
Father	Living/Deceased	_____	_____
Brothers:	Living/Deceased	_____	_____
	Living/Deceased	_____	_____
	Living/Deceased	_____	_____
Sisters:	Living/Deceased	_____	_____
	Living/Deceased	_____	_____
	Living/Deceased	_____	_____
Children:	Living/Deceased	_____	_____
	Living/Deceased	_____	_____
	Living/Deceased	_____	_____

9. Have you previously had any of the following diagnostic tests? If so, please indicate approximate date, name of physician, and hospital/clinic where performed.

Exercise Treadmill Test (Stress EKG test)

_____

_____

Holter Monitor (24 hour EKG) or Event Recorder

_____

_____

Nuclear Studies of the heart (these tests involve taking pictures of the heart after receiving a radioactive injection.) Most commonly used tests are: Adenosine Cardiolite Test and Cardiolite.

_____

_____

_____

Cardiac Catheterization (test in which dye is injected directly into the coronary arteries of the heart)

_____

_____

_____

Coronary Angioplasty (Balloon Procedure) or Stent Placement

_____

_____

_____

10. Have you previously been under the care of another cardiologist? Please state name, address and phone number of previous cardiologist.

_____

_____

_____