Northside Hospital Cardiovascular Care

Affix Patient Label Here

Patient's Name: Last, First
Account #: DOB

New Patient Health Questionnaire

"Please complete this form in its entirety prior to your visit as doing so will assist us greatly with your care."

CURRENT PROBLEM

Please briefly describe your main symptoms or reason for your visit today.

_____
_____
_____

What causes it: _____?

When did it start: _____ *(Date)*
Severity: _____ *(Scale of 1-10; 10 being most severe)*
Location: _____ *(Where do you feel the problem?)*
Character: _____ *(i.e.; sharp, dull, aching, pressure, racing etc.)*
Duration: _____ *(Amount of time-minutes/hours it lasts)*
How often: _____ *(# of times day/week/month)*
Modifying factors: _____ *(What makes it worse and what makes it better)*
Associated signs/symptoms: _____ *(Symptoms that consistently occur with the problem i.e.; nausea, shortness of breath)*

Have you seen another Physician in regards to this problem? _____

If yes, whom? _____ When? _____

Have you ever been to a Cardiologist before? _____ If yes, when? _____

Why? _____

LIST ANY ADDITONAL QUESTIONS THAT YOU MAY WANT TO DISCUSS DURING THIS VISIT:

1) _____
2) _____

FEMALE PATIENTS *(Please answer the questions below and **circle 'yes' or 'no'** when appropriate)*

1) Number of pregnancies? _____ Number of deliveries? _____
2) Date of last menstrual period: __-__-____, If not, have you had a Hysterectomy? **YES NO**
3) Did you ever have diabetes or high blood pressure during a pregnancy? **YES NO**
4) Have you ever had a preterm or low birth weight baby? **YES NO**
5) Do you have an autoimmune disease *(i.e. Lupus, Rheumatoid Arthritis)?* **YES NO**

PAST MEDICAL HISTORY

*Please **check** any of the following medical condition if you have been diagnosed with the condition recently or have had them in the past, we ask that you list any other conditions that may not be included below and the **number of years** that you have had the condition:*

□ __ Abdominal Distension
□ __ Abnormal EKG
□ __ Anxiety
□ __ Arthritis
□ __ Asthma
□ __ Atrial Fibrillation
□ __ Bleeding Disorder
□ __ CAD
□ __ Cancer
□ __ Congestive Heart Failure
□ __ COPD
□ __ Depression
□ __ Diabetes Mellitus-Type I
□ __ Diabetes Mellitus-Type II
□ __ Heart Attack
□ __ Heart Failure
□ __ Heart Murmur
□ __ High Blood Pressure
□ __ HIV Infection
□ __ HTN-Malignant, Essential
□ __ Hyperlipidemia
□ __ Hyperthyroidism
□ __ Hypothyroidism
□ __ Irregular Heart Beat
□ __ Kidney Disease
□ __ Metabolic Syndrome-X
□ __ Pacemaker, Cardiac
□ __ Peripheral Vascular Disease
□ __ Polycystic Ovaries
□ __ Preeclampsia, Antepartum
□ __ Preeclampsia, Postpartum
□ __ Reflux
□ __ Stroke
□ __ Transient Ischemic Attack
□ __ Other
□ __ _____
□ __ _____
□ __ _____
□ __ _____
□ __ _____
□ __ _____
□ __ _____

PAST SURGICAL HISTORY

*Please **check** any of the following **surgical procedures** if you have them or have had them in the past. Also please list any that may not be included:*

□ Abdominal Aortic Aneurysm repair
□ Ablation of Aberrant Conduction Pathway
□ AICD Placement
□ Atrial Septal Defect Repair
□ Aortic Valve Replacement
□ Aortic Valvuloplasty
□ Coronary Artery Bypass Graft
□ Femoral-Popliteal Vascular Bypass
□ Heart Transplant
□ Heart-Lung Transplant
□ Inferior Vena Cava Filter Placement
□ Mitral Valve Replacement
□ Mitral Valvuloplasty
□ Pacemaker Placement
□ Percutaneous Transluminal Coronary Angioplasty
□ Pericardiectomy
□ Pulmonary Valve Replacement
□ Repair of Congenital Cardiac Anomaly
□ Thoracic Aortic Aneurysm Repair
□ Tricuspid Valve Replacement
□ Tricuspid Valvuloplasty
□ Ventricular Septal Defect Repair
□ Other _____
□ _____
□ _____
□ _____

MEDICATIONS: (*List additional meds on the back page)*

MEDICATION	DOSE	FREQUENCY

ALLERGIES

Are you allergic to: □ Aspirin □ IV contrast dye □ Latex □ Penicillin □ Shellfish
Other Medications: _____
Describe the type of reaction: □ Itching □ Rash □ Respiratory □ Swelling □ Other: _____

FAMILY HISTORY *(Please **check or write** the appropriate answer to each question)*

*Please check below any member of **your immediate family** who has ever had a **Heart Attack, Diabetes, Angioplasty or Bypass Surgery, Cardiac Arrhythmia, Sudden Death, Cancer or other significant health problems**. If an **immediate family member** is deceased, please list the age and cause of death {Male younger than 55 year of age (or) Female younger than 65 years of age}.*

□ Mother: _____
□ Sibling-1: _____
□ Sibling-3: _____
□ Other: _____
□ Allergies
□ Arthritis
□ Asthma
□ Blindness
□ Cancer
□ Diabetes Mellitus
□ Ear Disorders
□ Genetic Disease/ Disorders
□ Hearing Loss
□ Heart Disease
□ Ischemic Heart Disease
□ Leukemia

□ Father: _____
□ Sibling-2: _____
□ Sibling-4: _____
□ Other: _____
□ Malignant Hyperthyroidism
□ Malignant Neoplasm
□ Mental Retardation
□ Ovarian Cancer
□ Skin Conditions
□ Stroke
□ Sudden Cardiac Death
□ Sudden Death due to other underlying cause
□ Other: _____
□ _____
□ _____
□ _____

SOCIAL HISTORY AND HABITS *(Please **check** the appropriate answer to each question)*

Please list your current Marital Status:
□ Single □ Divorced □ Married □ Separated □ Life Partner/ Civil Union □ Widowed
Occupation: _____
Do you exercise? □ Yes, If 'yes indicate the frequency by checking below **□ No**:
__ Sedentary (Sitting) __ Minimally (Once per Week) __ Active (no formal exercise routine)
__ Moderately (1-3 times weekly) __ Regularly (Consistently) __ Heavily (greater than 4 times weekly)

Do you drink or indulge in any of the following substances and if so, please indicate the frequency:

Alcohol	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)
Caffeine	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)
Cocaine	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)
Depressants	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)
Illicit Drugs	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)

*If **'yes'**, please list the type of substance:* _____

Marijuana	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)
Tobacco	□ Yes: _ Daily __ Occasionally	__ Seldom	__ Rehabilitated	□ No (Never)

*If **'yes'**, please list the type of substance:* _____
How often? _____ *How much (example: cigarettes 1 pack)?* _____

REVIEW OF SYSTEMS: (*Please verify if you have had any of the following within the last 30 days)*

CONSTITUTIONAL	**YES**	**NO**
Fever	□	□
Chills	□	□
Excessive fatigue	□	□
Weight Gain	□	□
Weight Loss	□	□

EYES		
Glaucoma	□	□
Changes in vision	□	□
Blurred vision	□	□
Wearing Glasses/ Contacts	□	□

EARS, NOSE, MOUTH, AND THROAT		
Decrease in hearing	□	□
Ringing of the ears	□	□
Nosebleed	□	□
Sinus Problems	□	□
Sore Throat	□	□
Vocal Changes	□	□

CARDIOVASCULAR		
Chest Pain	□	□
Heart Racing/ Skipping	□	□
Irregular Heart Beats	□	□
Shortness of Breath w/exercise	□	□
Awakening from Sleep	□	□
Deep Vein Thrombosis	□	□
Venous Dysfunction	□	□
Varicosities	□	□

RESPIRATORY		
Snoring	□	□
Wheezing	□	□
Cough	□	□
Shortness of breath	□	□
Sleep Apnea	□	□

GASTROINTESTINAL		
Abdominal pain	□	□
Reflux/ Heartburn	□	□
Nausea / Vomiting	□	□
Blood in Stools	□	□
Loss of Appetite	□	□
Diarrhea/ Constipation	□	□
Irritable Bowel Syndrome	□	□
Change in Bowel Movement	□	□
Liver Disease/ Cirrhosis	□	□
Hepatitis	□	□

GENITO-URINARY	**YES**	**NO**
Prostate Disease	□	□
Blood in Urine	□	□
Difficulty Urinating	□	□
Post-Menopausal	□	□
Frequent Urination	□	□
Burning / Painful Urination	□	□

INTEGUMENTARY (SKIN)		
Bruising	□	□
Rash	□	□
Itching	□	□
Varicose Veins	□	□

NEUROLOGICAL		
Stroke	□	□
Seizures	□	□
One sided weakness	□	□
Frequent/ Recurrent Headaches	□	□
Light Headed/ Dizziness	□	□
Tingling/ Numbness	□	□

MUSKULOSKELETAL		
Muscle pain	□	□
Muscle Cramps	□	□
Joint Pain	□	□
Back Pain	□	□
Arthritis	□	□
Gout	□	□

ENDOCRINE		
Excessive Thirst	□	□
Excessive Urination	□	□
Cold Intolerance	□	□
Heat Intolerance	□	□

PSYCHIATRIC		
Depressed	□	□
Anxiety	□	□
Nervousness	□	□
Difficulty Sleeping	□	□

HEME-LYMPH		
Anemia	□	□
Low platelets	□	□
Easily Bruised	□	□
Easy Bleeding	□	□
Swollen Glands	□	□
Previous Blood Transfusion	□	□