Patient History Questionnaire –Please bring to your appointment!

PATIENT INFORMATION

Last Name ___________________**First** _________________**MI**___ Sex M F Date:____________
Referring physician: ______________________________ Birth date: _______________ Age: _______
Primary Dr: _____________________________Cardiologist__________________________________
Other Doctors ____

Race: ***(Circle One)*** White Am. Indian/AK Native Asian Black/African Am. Nat. Hawaiian Other Race Declined

Ethnicity: ***(Circle One)*** Hispanic or Latino Non-Hispanic or Latino Declined

HISTORY OF PRESENT ILLNESS
Reason for your visit: ____

♦ Location of Problem: ____________________________________Duration: _____________________
(Where on the body symptom occurs- Right or Left side if applicable) ***(How long have you had symptom? How long does it last?)***

♦ Severity: _______________________________________ Quality: ____________________________
(Severe, worse, slightly. Pain scale 1-10) ***(Character of symptom...burning, gnawing, stabbing)***

♦ Timing: ____ Context: ____________________________
(When symptoms occur) ***(Situation associated with symptom)***

♦ Modifying Factors: ____
(Things that make symptoms better or worse)

♦ Associated Signs/Symptoms: ____
(Other things that happen when this symptom occurs)

Medical History: *Please circle **Yes** or **No** if you have the following medical problems& explain below.*
High Blood Pressure . . ..Yes No Respiratory Problems . . ..Yes No >Type ____________________
Diabetes ……………. .Yes No Bleeding Problems. . . . .Yes No>Type_____________________
Stroke…………… . . . .Yes No Heart Trouble………….Yes No> Type_____________________
Cancer……………….. Yes No >> Type____
Other Problems____

What is your current weight? ________________ Height? ____feet ______inches

Preferred Pharmacy____________________________ Location/Phone________________________
Current Medications/Dosage:

____
____
____

Drug Allergies: ____
____
Are you allergic to contrast dye? Yes No

Continue on reverse side of page

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

____

____

____

____

Family History: *Please list any medical problems in your relatives.*

Father: ____

Mother: ____

Siblings:____

Others:_____________________ ____

Social History: Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Tobacco Use:❑ Never ❑ Quit/ What age? _______ ❑ Smoker/ how much?___________

Alcohol Use: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ❑ How much?________________

Recreational Drug Use: ❑ Never ❑ Type and frequency ____________________________

Occupation: _________________________ Permanent Resident? Yes No

Review of Systems *Please circle* ***Yes*** *or* **No** *if you have any of the following problems.*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nose bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Wheezing/asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
Muscle pain or cramp	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain/discharge	Yes	No
Endocrine			**Hematologic / Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
Genitourinary -Male only			**Genitourinary -Female only**			**Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Other ______________		

_____

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed ____ **Date**___________________________________