

PATIENT QUESTIONNAIRE

Name: Mr. Mrs. Ms. _____

Referring MD _____ Personal MD (if different) _____

Reason for visit (check all appropriate boxes):

- Chest pain Dizziness Weakness Fluid retention Heart murmur
- Shortness of breath Fainting Air hunger Cough Medicine adjustment
- Palpitation Swelling Doctor sent me Rhythm problem Heart attack
- Angina High blood pressure

Please circle the symptom which you feel is most important. Check box for chest pain if you experience any form of chest discomfort.

Hospitalization for surgery:

1. _____
OPERATION _____ HOSPITAL _____ DATE _____
2. _____
OPERATION _____ HOSPITAL _____ DATE _____
3. _____
OPERATION _____ HOSPITAL _____ DATE _____
4. _____
OPERATION _____ HOSPITAL _____ DATE _____
5. _____
OPERATION _____ HOSPITAL _____ DATE _____

Hospitalizations for illness:

1. _____
OPERATION _____ HOSPITAL _____ DATE _____
2. _____
OPERATION _____ HOSPITAL _____ DATE _____

Allergies: Check here if none

- Penicillin Aspirin Tetanus _____ Seafood
- Sulfur Novocaine Cortisone _____ Shellfish
- Tetracycline Iodine _____ _____ Pollen

Hay fever: Yes No

Asthma: Yes No

Hives: Yes No

YOUR FAMILY

Mother: Age _____ Living Dead Cause of death _____

Father: Age _____ Living Dead Cause of death _____

Brother(s) age(s) _____ Sister(s) age(s) _____ (L=Living D=Dead)

Write relatives who has had any of the following illnesses (when appropriate):

- Allergy / Asthma _____ Ulcer Disease _____ Gall Bladder _____
- Arthritis _____ Kidney / Urinary _____
- Anemia _____ Diabetes _____ Gout _____
- Bleeding _____ Rheumatoid Arthritis _____
- Carcinoma (Cancer) _____ Glaucoma _____ Stroke _____
- Rheumatic Fever _____ Tuberculosis _____ Epilepsy _____
- Hypertension (High blood pressure) _____ Congenital Heart Defect _____

Please list all medicines, doses, and times you take them.

Do you smoke now? Yes No If you quit, when _____

Do you smoke: cigarettes pipe cigars How many per day? _____

When did you start? (age) _____

Do you drink coffee? Yes No More than three cups per day? Yes No

Do you drink more than 12 oz. beer, 6 oz. wine, 3 oz. whiskey per day? Yes No Have you ever? Yes No

Do you take vitamins? Yes No Which? _____

Do you use more than four aspirin per week? Yes No

Do you use over the counter medicines (nasal sprays, decongestants, allergy pills, etc.) REGULARLY / DAILY? Yes No

Have you ever had (check) Hepatitis Mononucleosis EB Virus Malaria Anemia (Check here if none:)

Have you ever been told you had a heart murmur? Yes No