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