

NOVA Cardiovascular Care, Inc
Patient History Questionnaire

Today's Date: ____/____/____

Name: _____ Date of Birth: ____/____/____

Age: _____

Referring Doctor: _____

How did you hear about our practice? referring doctor friend internet/website other _____

Why are you here to see a cardiologist? _____

Please check (✓) the box if **YOU HAVE HAD** or **CURRENTLY HAVE** any of the following:

CARDIOVASCULAR SYSTEM

- Angina/Chest Pain/Chest Discomfort
- Arrhythmia/Palpitations
- Irregular Pulse
- Dizziness
- Enlarged Heart
- Fainting/Near fainting
- Heart Attack
- Congestive Heart Failure
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- High Cholesterol
- Rheumatic Fever
- Swollen Legs/Edema
- Leg Cramps with exertion
- Erectile Dysfunction
- Vascular Disease
 - Abdominal Aortic Aneurysm
 - Lower Extremity/PVD
 - Carotid Artery Disease

ALLERGIES/IMMUNOLOGY

- Seasonal Allergies
- Food Allergies
- Hives

NEUROLOGICAL

- Neuropathy
- Vision Loss
- Hearing Loss
- Stroke/TIA
- Seizure

RESPIRATORY SYSTEM

- Asthma/COPD/Bronchitis
- Cough
- Pneumonia
- Shortness of Breath
- Obstructive Sleep Apnea

RENAL/UROLOGICAL

- Kidney Disease
- Blood in Urine
- Kidney Stone
- Painful urination
- Prostate Enlarged

RHEUMATOLOGIC

- Gout
- Arthritis/Joint Swelling
- Muscle Aches
- Connective Tissue Disease

INFECTIOUS DISEASE

- Hepatitis
- HIV/AIDS

ENDOCRINE SYSTEM

- Diabetes
- Fever or Night Sweats
- Thyroid Disease
- Weight Gain/Loss

GASTROINTESTINAL SYSTEM

- Gastrointestinal Bleeding
- Blood in Stool
- Gall Stone

- Hiatal Hernia
- Reflux/Heartburn
- Ulcers
- Liver Disease
- Hepatitis
- Nausea or Vomiting

HEMATOLOGICAL/ONCOLOGICAL

- Cancer-Type: _____
- Anemia
- Bleeding Disorder
- Thrombophilia/Clotting Disorder
- Blood Clots in Legs or Lungs

PSYCHOLOGICAL

- Anxiety/Panic Attacks
- Depression
- Insomnia
- Other Psychotic Disorder

HAVE YOU EVER HAD:

- ECG/EKG
- Stress Test
- Echocardiogram
- Heart Catheterization
- Coronary Angioplasty/Stent
- Coronary Bypass Surgery
- Valve Surgery
- Pacemaker or Defibrillator
- Electrophysiology Study/Procedure
- Cardiac CT or Calcium Score

NEXT PAGE

Who do you **LIVE WITH?**: _____ Married Single Partner Divorced

OCCUPATION/TYPE OF WORK: _____

Ever **SMOKED?**: NO YES If yes, how many years _____, _____ packs per day? When did you quit? _____

Do you **DRINK ALCOHOL?**: NO YES If yes, how much? _____

Do you use **RECREATIONAL DRUGS?** (i.e.: cocaine, marijuana, heroin, etc) NO YES If yes, what kind? _____

Do you **DRINK CAFFEINE?**: NO YES If yes, how much _____

Do you **EXERCISE?**: NO YES If yes, how often _____, what kind _____ and where _____

List **FAMILY HEALTH PROBLEMS** such as: Hypertension, Diabetes, Coronary Artery Disease, Stent, CABG, Valve Surgery, Hyperlipidemia, AAA, CHF, Cardiomyopathy, Arrhythmias, Unexplained or Sudden Death, Congenital Heart Disease,

Age(s) Alive or Deceased Problems

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Other _____

Please List ALL Medical Problems, Operations and Injuries You CURRENTLY HAVE or HAVE HAD IN THE PAST

Are you **ALLERGIC TO IODINE or Contrast Dye?**: NO YES _____

Are you **ALLERGIC TO ANY MEDICATIONS?**: NO YES

If yes, please list medication name and the reactions

Please list all medicines you are **currently taking**. Include over-the-counter medicines as well as prescription drugs.

Name	Dose/Strength	Frequency	Name	Dose/Strength	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FOR OFFICE USE ONLY

HT: _____ WT: _____

BP R: _____ BP L: _____ PULSE: _____