Northern Virginia Cardiology Associates, P.C.

Patient History Questionnaire

Today's Date: _____/_____/_____

________________________	______/______/______	______	________________________
Patient's Name	DOB	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

HEMATOLOGICAL/ONCOLOGICAL
- ☐ Cancer-Type: ______________
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Thrombophilia/Clotting Disorder
- ☐ Blood Clots in Legs or Lungs

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

ALLERGIES/IMMUNOLOGY
- ☐ Seasonal Allergies
- ☐ Food Allergies
- ☐ Hives

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

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

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

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

OVER

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

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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 ____

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____

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: __________