*Thank you for choosing TrustCare Heart Clinic for your cardiovascular needs.*

# NEW PATIENT QUESTIONNAIRE

Name _____ Date of Birth _____ /_____ /_____

Referring Physician (IF DIFFERENT) _____

Pharmacy _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

What is the reason for your visit today? (please include any symptoms you have had or are currently experiencing)

_____

Current Medications: (please make sure you bring ALL medications with you to your appointments)

Please list ALL medications (prescription and non-prescription) that you currently take. If you need additional space, please list them on the back of this page:

| Medication Name | Dosage | How often do you take it | Prescribed by |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Allergies: Do you have Allergies to Iodine, seafood or radiographic contrast dye? (Circle) Yes / No

Please list ALL allergies and describe the reaction to them:

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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**Social History**: Please answer ALL questions.

Occupation _____ Number of children _____

Do you currently smoke? Yes / No If yes, how much? _____ How long? _____

Have you ever smoked? Yes / No Do you currently use smokeless tobacco? Yes / No

Do you drink alcohol? Yes / No If yes, how much? _____ How long? _____

Have you ever used illicit drugs? Yes / No If yes, what kind? _____ How long? _____

Do you exercise? Yes/ No If yes, how often? _____

How much caffeine (coffee, tea, soft drinks) do you drink daily? _____

**Family History**: Please answer ALL question as they apply to your mother, father, siblings, and children.

Any history of the following:

Heart Disease? Yes / No Whom: _____ Stroke? Yes / No Whom: _____

Cancer? Yes / No Whom: _____ Diabetes? Yes / No Whom: _____

High Blood Pressure? Yes / No Whom: _____

**Past Surgical History**: Please list ALL your prior surgeries:

| Surgery | Date | Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Past Medical History**: Please answer ALL questions.

Do you have any of the following:

Hypertension (high blood pressure): Yes / No Diabetes: Yes / No

History of smoking/current smoker: Yes / No High cholesterol: Yes / No

| Do **you** personally have a history of the following: | Yes | No | Details (e.g., dates, hospitals, treating physicians) |
|---|---|---|---|
| Known coronary artery disease? | | | |
| Heart attack requiring hospitalization | | | |
| Coronary artery stenting | | | |
| Coronary artery ballooning only | | | |
| Coronary artery bypass surgery | | | |
| Heart rhythm disorders? | | | |
| Pacemaker | | | |
| Defibrillator (ICD) | | | |
| Atrial fibrillation | | | |
| Atrial flutter | | | |
| Ventricular arrhythmias | | | |
| Cardioversion | | | |
| Ablation procedure | | | |
| Heart Failure? | | | |
| A heart murmur? | | | |
| Mitral valve prolapse? | | | |
| Rheumatic heart disease? | | | |
| High blood pressure (even if treated)? | | | |
| High cholesterol (even if treated)? | | | |
| Diabetes (even if treated)? | | | |
| Stroke? | | | |
| Black out or fainting spell? | | | |
| Aortic aneurysm (enlarged aorta)? | | | |
| Thyroid disorder? Explain | | | |
| Asthma/ Emphysema/ COPD? | | | |
| Stomach/ peptic ulcers? | | | |
| Gastrointestinal bleeding? | | | |
| Heartburn/ Reflux (GERD)? | | | |
| Lung cancer? | | | |
| Colon cancer? | | | |
| Breast cancer? | | | |
| Prostate cancer? | | | |
| History of a blood clot? (DVE/PE) | | | |
| Bleeding disorder? | | | |

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**Review of Systems:** Please indicate if you are **CURRENTLY** experiencing any of the following:

How many flights of stairs can you climb without stopping? _____

How many pillows do you sleep on at night? _____

| | YES | NO | PAST |
|---|---|---|---|
| **CONSTITUTIONAL** | | | |
| Recent change in weight | | | |
| Unexplained Fever | | | |
| Chills | | | |
| Night Sweats | | | |
| Decreased appetite | | | |
| Fatigue | | | |
| Inability to sleep | | | |
| **EYES** | | | |
| Recent change in vision | | | |
| Blurred/Double vision | | | |
| Eye pain | | | |
| Wear glasses/contacts | | | |
| Cataracts | | | |
| Glaucoma | | | |
| **EARS/ NOSE/ MOUTH/ THROAT** | | | |
| Dry Mouth | | | |
| **GASTROINTESTINAL** | | | |
| Nausea | | | |
| Vomiting | | | |
| Abdominal pain | | | |
| Diarrhea | | | |
| Constipation | | | |
| Heartburn/ reflux | | | |
| Blood in stool | | | |
| **CARDIOVASCULAR** | | | |
| Chest pains | | | |
| Palpitations | | | |
| Inability to sleep lying flat | | | |
| Swelling in the legs or feet | | | |
| Muscle pains while walking | | | |
| Awakening short of breath | | | |
| Lightheadedness | | | |
| Loss of consciousness | | | |
| Decreasing exercise tolerance | | | |

| | YES | NO | PAST |
|---|---|---|---|
| **MUSCULOSKELETAL** | | | |
| Pains in joints | | | |
| Muscle pain | | | |
| Bone fractures | | | |
| Pain in the bones | | | |
| **GENITOURINARY** | | | |
| Urination frequently | | | |
| Urinate suddenly | | | |
| Increase urination at night | | | |
| Blood in urine | | | |
| Pain while urinating | | | |
| Urinary incontinence | | | |
| **DERMATOLOGICAL** | | | |
| Rashes | | | |
| Ulcers | | | |
| Hair loss | | | |
| Change in skin | | | |
| **ENDOCRINOLOGIC** | | | |
| Intolerance to heat | | | |
| Intolerance to cold | | | |
| Increased need for fluids | | | |
| **HEMATOLOGICAL** | | | |
| Easy bleeding | | | |
| Easy bruising | | | |
| Swollen glands | | | |
| Swollen lymph nodes | | | |
| **ALLERGIC/ IMMUNOLOGIC** | | | |
| Diffuse itching | | | |
| Anaphylaxis | | | |
| Swelling of the throat | | | |
| **PSYCHIATRIC** | | | |
| Depressed mood | | | |
| Inability to enjoy anything | | | |
| Anxiety | | | |
| Suicidal thoughts | | | |

| **RESPIRATORY** | | | |
|---|---|---|---|
| Shortness of breath | | | |
| Coughing up phlegm | | | |
| Coughing up blood | | | |
| Wheezing | | | |
| | | | |

| Hallucinations | | | |
|---|---|---|---|
| Stress | | | |
| **NEUROLOGICAL** | | | |
| Weakness of arm/leg | | | |
| Severe headaches | | | |
| Memory loss | | | |