

PATIENT MEDICAL BACKGROUND QUESTIONNAIRE

Patient Name: _____ **Birthdate:** _____

Do you have a history of the following conditions? Please check the appropriate box for each category and include the year of diagnosis for all that apply.

Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Irregular Heart Rhythm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Atrial Fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Was this documented on an EKG?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Date of Monitor _____
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	How Often _____
Syncope (Passing Out)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	How Often _____
Congestive Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Defibrillator (ICD) Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Placement _____
Pacemaker Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Placement _____
Coronary Artery Bypass Grafting (CABG)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Date of Procedure _____
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Pancreatic Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Asthma/ Chronic Obstructive Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Vascular Disease of Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Prior blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Transient Ischemic Attack (TIA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Carotid Disease or Bruit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Bleeding from Stomach /Intestines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____

PATIENT MEDICAL BACKGROUND QUESTIONNAIRE (page 2)

Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Type of Cancer: _____	Type of Treatment: _____			_____
High Cholesterol/Triglycerides	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Treatment with medication?	_____			_____
Blood clots in lungs or legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Year of Diagnosis _____
Alcohol Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Amount in 1 week: _____
Tobacco Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Type of Tobacco: _____ Amount: _____

Surgery: Please list any surgery you have had:

Date or Year of Surgery/Location

Heart Surgery _____

Valve Surgery _____

Other Surgery _____

Have you had any of the following tests?

Test

Date or Year of Testing/Location

Cardiac Stress Test _____

Echocardiogram _____

Cardiac angiogram /
Catheterization _____

Holter Monitor _____

Event Recorder _____

Carotid Studies _____

Tilt Table Study _____

Electrophysiology Study _____

EEG _____

MRI _____

CT of Head _____

Any other cardiac testing _____

PATIENT MEDICAL BACKGROUND QUESTIONNAIRE (page 3)

Have you ever had chest pain? Yes No

If yes, please describe the location, how long it lasted, how often it occurred, and any changes that occurred with discomfort (i.e. pain in neck/arms, sweating, nausea, or shortness of breath).

Please list any other health conditions you have:

Family History: List medical conditions found in your parents, siblings, aunts, uncles, cousins, and children. Please state age at onset of condition. If your parents are deceased please list their age at death and the cause. Mark alive, or when died. List how many siblings you have, if any family members died suddenly, and if any have heart conditions.

Father: _____

Mother: _____

Siblings (How many): _____

Other: _____

Allergies/type of reaction: _____

Please list current medications (If more than 6 medications list remainder on the back of this sheet.)

Name of Medication	Dosage	Time taken during the day
1		
2		
3		
4		
5		
6		

Pharmacy Name: _____ **Pharmacy Phone #** _____

Physicians

Name of the Primary Physician in charge of your healthcare: _____

Other Physicians and Specialists : Name _____ Specialty _____

Name _____ Specialty _____