Patient Questionnaire

Dear Patient,

We are in the process of converting our records from paper charts to computer charts. As we do this, we want to double check the information we have. Will you please assist us by completing the following? At future visits, we may print your information and ask you to check it over for accuracy. Thanks very much for your assistance.

Patient's Name ________________________________ **Patient's Date of Birth** _____________

Pharmacy Name and location ____________________________ **Today's Date** ____________

Who is your primary cardiologist in The Ohio Heart? ________________________________

Who is your primary care physician? ____

HAVE YOU BEEN ADMITTED TO THE HOSPITAL OR HAD A PROCEDURE OR LAB WORK SINCE YOUR LAST VISIT?

If so, when or what? ____

Do you CURRENTLY have any of the following problems:

Y	N		Y	N		Y	N	
❍	❍	Chest Pain	❍	❍	Sweating (when not exercising)	❍	❍	Difficulty breathing when lying flat
❍	❍	Palpitation	❍	❍	Fainting or passing out	❍	❍	Suddenly awakened with severe shortness of breath
❍	❍	Leg or hip pain when walking. Relieved by sitting down.	❍	❍	Swelling in your ankles or hands			
❍	❍	Weight Gain	❍	❍	Weight Loss	❍	❍	Fever
❍	❍	Vision Changes	❍	❍	Hearing Loss			
❍	❍	Snoring	❍	❍	Coughing up blood	❍	❍	Shortness of breath
❍	❍	Nausea	❍	❍	Acid Reflux	❍	❍	Rectal Bleeding
❍	❍	Blood in Urine	❍	❍	Waking up frequently at night to urinate			
❍	❍	Dizziness	❍	❍	Memory Loss	❍	❍	Seizures
❍	❍	Depression	❍	❍	Hallucinations			
❍	❍	Acute Anemia	❍	❍				
❍	❍	Erectile Dysfunction	❍	❍	Hx of Oral Contraceptives			
❍	❍	Goiter	❍	❍	Tremors/shakes			
❍	❍	Rash	❍	❍	Skin Sores			
❍	❍	Joint Pain	❍	❍	Muscle ache			

See Other Side, Please

Have you had any other medical conditions not listed above? ☐ **Yes** ☐ **No**
If yes, please list condition and approximate date(s).

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Have you had any surgeries in the past? ☐ **Yes** ☐ **No**
If yes, please list surgeries and approximate dates.

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Are you: married/single/divorced/separated/widowed/domestic partner/living alone?

Occupation ______________________ ❐**Disabled** ❐**Retired**

Children: # Sons _______ **# Daughters** ________

Tobacco: ❐No ❐Current ❐Former (Year Quit _______) Packs/Day ______ Yrs Smoked ____

Alcohol: ❐Yes ❐No ❐Former ❐Occasionally ❐Rarely ❐Social ❐Daily ❐Frequently

Please answer the following about your family. Has your father, mother, sister or brother had a history of heart disease? If so, which one, and at what age was the problem first diagnosed?

Father:

Mother:

Sister:

Brother:

Please answer the following about yourself:

Have you been diagnosed as having diabetes? ❐**Yes** ❐**No**
If yes: Year of onset was ______________.

❐**Type 1(juvenile) or** ❐**Type 2(adult onset)?**
Insulin dependent? ❐**Yes** ❐**No**

Do you have hypertension? ❐**Yes** ❐**No** **Year Diagnosed __________.**

Do you have high cholesterol? ❐**Yes** ❐**No**

Do you have peripheral vascular disease? ❐**Yes** ❐**No** ❐**Unknown**

Do you have any allergies or other reactions to a medication? If so, what medication and what kind of reaction?

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