PACIFIC HEART
ASSOCIATES, PC

CARDIOLOGY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:						☐ M ☐ F	**DOB:**
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
Previous or referring doctor:				**Date of last physical exam:**			

PERSONAL HEALTH HISTORY

Heart History	Please list the date and hospital where treated or performed
☐ Heart Attack	☐ Angiogram
☐ Heart Failure	
☐ Bypass Surgery	☐ Angioplasty/Stent
☐ Valve Surgery	

Medical History

High Blood Pressure	☐	Yes	☐	No	Stroke	☐ Yes	☐	No
High Cholesterol	☐	Yes	☐	No	Rheumatic Fever	☐ Yes	☐	No
Diabetes	☐	Yes	☐	No				

List any other medical problems that other doctors have diagnosed

Surgeries

Year	Type	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Drug	Strength	Frequency Taken

Allergies to medications	
Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit	(please fill in above for the amount you used to use)			
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	Men: Do you use medications for erectile dysfunction (Viagra, Levitra, Cialis)?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

***** PLEASE LIST AGE OF DIAGNOSIS FOR ANY HEART CONDITIONS *****

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Recent changes in:	☐ Weight	☐ Energy level
☐ Skin	☐ Heart	☐ Blood disorders
☐ Eyes	☐ Stomach/Intestinal	☐ Muscles / Joints
☐ Ears / Nose / Throat	☐ Bladder/Urination	☐ Infections
☐ Lungs	☐ Endocrine/thyroid	☐ Other:
☐ Neurologic	☐ Psychiatric	