Patient History Questionnaire

Patient Name:_____

Marital Status: Single Married Widowed Divorced

Occupation:_____

1.Reason for Visit:

2. Have you been experiencing any of the following symptoms?

Symptom	Yes	No
Chest Pain		
Dizziness		
Fainting		
Palpitations		
Leg Cramps		
Shortness of Breath		
Swollen Legs		

3. Have you been diagnosed with any of the following conditions:

Diagnoses	Yes	No
Diabetes		
Heart Attack		
Heart Murmur		
High Blood Pressure		
High Cholesterol		

4. Have you had any of the following?

Test	Yes	Which hospital or facility	No
Stress Test			
Echocardiogram			
EKG			
Heart Catherizations			
Bypass Surgery			

Valve Surgery			
Angioplasty			
Lab Work			
Other Operations (Please Specify)			

5. Do you take estrogen?_____

6. Tobacco History:

Current Former Never

Type: Cigars, Cigarettes, Chewing, Pipe

Current- How many packs a day _____, How many years _____

Former- What year did you quit? _____, How many years did you smoke? _____

7. Alcohol History:

Current Former Never

Type:_____

How Frequently: _____

8. Activity:

Do you exercise?_____ How Frequently_____

9. Do any of your close relatives have the following conditions:

Conditions	**Relative**
Heart issues	
High Blood Pressure	
Diabetes	
High Cholesterol	
Vascular Disease	
Cancer	

10 .Do you have any medication allergies?_____

Patient Signature:_____ Date:_____