HIGHLAND HOSPITAL CARDIOLOGY
PATIENT QUESTIONNAIRE

Name: _____Date:_____

DOB :_____ Age: _____ Referred by:_____

Why are you here today? _____

_____

Past Cardiac History - circle what you have

High Blood Pressure High Cholesterol Heart Attack Stroke/Mini Stroke Diabetes
Bypass Surgery Irregular Heart Beats Rheumatic Fever Chest Pain Shortness of Breath

_____

Family Cardiac History - circle what family has

High Blood Pressure High Cholesterol Diabetes
before age 50 if male, age 60 if female
Sudden Death Heart Attack/Stent/Heart Surgery Stroke/Mini Stroke

Other:_____

Past Medical History - circle what you have

Thyroid Problems Lung Disease Headaches Lightheadedness Blood Clots
Cancer Anemia Kidney Problems Arthritis Depression
Stomach Problems Seizures Vision Problems

Other:_____

Past Surgical History

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

(complete other side)

Current Medications - Please provide an updated list to the nurse or bring your pill bottles.

Allergies:_____

Personal History - Circle

Single Married Divorced Separated Widow(ed) # of Children:_____

Education:_____ Who lives with you:_____

Occupation:_____Employer:_____

Do you smoke: yes no quit when/how many packs: _____

Do you drink alcohol: yes no How often: _____ What Kind:_____

Do you use illicit drugs: yes no What/when:_____

Have you ever seen a cardiologist before? yes no Why/when:_____

Was testing done? yes no What:_____

I learn best by (circle one): Reading Demonstration Discussion Video

I would like more information about (circle one):
Heart disease Diet Cholesterol Exercise Prescribed medications

Next of Kin/Emergency Contact:_____

Relationship: _____ Phone: _____

How can we reach you? Preferred phone number:

Home:_____Cell:_____Work:_____