



Helena Cardiology Clinic Patient Questionnaire

Date

Name

Last

First

Middle Initial

Social Security Number - -

Date of Birth / /

Medications:

Name	Dose	Dose Schedule
		once daily
		once daily
		once daily
		once daily
		once daily

Are you allergic to anything? Yes No

If yes, name of drug:

Type of Reaction: Rash Hives Trouble Breathing

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What is your marital status?

What is your chief reason for coming to see us?

Who is your primary care provider?

1.

Are you currently having any of these symptoms?

(Check all that apply)

Chest Pain Jaw Pain Shoulder Pain Arm Discomfort or
 Back Discomfort

Shortness of breath

Other

How long have you had this?

What does it feel like? (Check all that apply)

Tightness Pressure Indigestion Aching Heaviness Pain

Other

Is there anything that brings it on?

No or Yes

If yes, what? Yard work Climbing Stairs Walking

Does it ever occur: When you are not doing anything? No or Yes

After a meal? No or Yes

Does it awaken you from sleep? No or Yes

How often does it occur? Daily Couple of days/week Weekly Monthly Other

2. Have you had a Stress Test of any kind recently?

Treadmill? Date: Where: Results:

Nuclear Imaging Study? Date: Where: Results:

Echocardiogram? Date: Where: Results:

3. Have you ever had a heart attack? No or Yes

If yes, when?

4. Have you had any procedures done on your heart? No or Yes

Coronary artery bypass graft surgery? Date: Where: Number of grafts:

Heart Catheterization Date: Where:

Angioplasty and/or stenting? Date: Where: Which vessels(s):

Surgery on your heart valves? Date: Where: Which valve(s):

5. Do you currently smoke? No or Yes

If Yes, how many packs per day do you smoke?
How many years have smoked?

If you do not currently smoke, have you ever smoked? No or Yes

If Yes, when did you quit?
The most number of packs per day you smoked?
How many years did you smoke?

6. Are you diabetic? No or Yes

If yes, how long have you been diabetic?

Do you take Insulin? No or Yes

7. Do you have high blood pressure? No or Yes If yes, for how long:

8. Do you have high cholesterol? No or Yes If yes, for how long:

9. Are there any members of your family that have heart disease? No or Yes If yes, Who:
No or Yes
 If yes, is there anyone that has had a heart attack or procedure done on their heart when they were below the age of 55? No or Yes
 If Yes, Who?
 What did they have done?

Have you had contrast dye before? No or Yes

If yes, did you have any adverse reaction? Yes or No

If yes, what type of reaction? Hives Swelling Breathing difficulty

10. What is your work status? Work, retired, (if retired where did you work and for how long)

11. Have you had any surgeries? No or Yes
 If yes, what type of surgery?

Date: Where:

Peripheral Arterial Disease Screening

- Do you have any weakness or discomfort in your:
 - Calves No Yes
 - Thighs No Yes
 - Hips No Yes
 - Buttocks No Yes
- When does this occur: At rest? No Yes
 With Activity? No Yes
 How far can you walk before getting this discomfort? _____
- Do you have skin wounds or ulcers on your feet or toes that are slow to heal? No Yes
- Are your toes or feet pale, discolored or bluish? No Yes

Review of Systems:

Do you have any of the following?

- Blood clots in your legs or your lungs? No or Yes
- Liver Disease? No or Yes
- Bowel, kidney or bladder disorder? No or Yes
- Neurological-stroke or endocrine disorder-diabetes, thyroid disorder? No or Yes
- Peptic Ulcer Disease? No or Yes