Patient Medical Questionnaire

Heart Clinic of Louisiana

(504) 349-6800

Last Name _____ First Name _____

Date of Birth _____

Primary Physician's name _____ Referring Physician _____

Did someone other than your physician refer you? (Yes / No)

Shall we send a report to your physician? (Yes / No)

Present Illness

What is the chief problem that brings you to the clinic? _____

_____

_____

_____

How long have you had the problem? _____

What do you think may be causing it? _____

What makes the problem worse? Better? _____

Do you associate any other symptoms with the problem? (Nausea, light-headedness, etc) _____

_____

Have you ever seen a cardiologist before? _____

Previous Studies – Circle – Then write any details you can recall including the year.

☐ Heart Cath or Angiogram _____

☐ Echo or Heart Ultrasound _____

☐ Stress Test or Treadmill _____

☐ Carotid Ultrasound _____

☐ EKG _____

☐ MRI or CT Scan _____

☐ PFT's or Lung testing _____

☐ Abdominal Ultrasound _____

Past Medical and Surgical History

Year	Illness/Operation	Notes
____	_____	_____
____	_____	_____
____	_____	_____
____	_____	_____

☐ Asthma ☐ Cancer ☐ Stroke
☐ Heart Murmur ☐ Ulcers
☐ Diabetes ☐ Radiation
☐ Rheumatic Fever ☐ Thyroid
☐ Kidney Problems
☐ High Cholesterol
☐ High Blood Pressure

Family History (in whom)

Heart Disease _____

High Blood Pressure _____

High Cholesterol _____

Stroke _____

Diabetes _____

Other _____

Medicines: List all medicines (vitamins, aspirin, and all) that you have been taking recently.

Name	**Dose** (mgs & times/day)	**How long?** Months/ Years
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (or reactions to medicines or other substances) List all. _____

Social History

Do you smoke? (Yes/No) Have you ever smoked? (Yes/No) Year quit____ Pks/day ___ Yrs ___

Have you tried to quit? (Yes/No) Do you want to quit? (Yes/No)

Do you drink? (Yes/No) How much? Rare / Socially / Light (1-2 drinks/ day max) / More

Have you tried to quit? (Yes/No) Do you want to quit? (Yes/No)

Do you exercise regularly? (Yes/No) What kind and how often. _____

Do you drink caffeine? (Yes/No) – Cups/Glasses / day. ____Use of recreational drugs? (Yes/No)

Occupation _____ Education? _____ Disabled (Yes/No) Retired (Yes/No)

Review of Symptoms

☐ Recent weight loss or gain	☐ Unexplained fever/sweats	☐ Dizziness
☐ Extreme fatigue/tiredness	☐ Cold or Heat intolerance	☐ Calf pain with walking
☐ Unexplained weakness	☐ Temporary visual loss	☐ Difficulty speaking
☐ Loss of feeling in arms/legs	☐ Loss of memory	☐ Coughing up blood
☐ Increased stress	☐ Difficulty sleeping	☐ Blood or black stools
☐ Stomach pain	☐ Indigestion	☐ Frequent night urination
☐ Recent accident	☐ Easy bleeding	☐ Depression

Is there anything that we have left out, that you feel should be mentioned? _____

_____

Date: _____ Patient Signature: _____ Physician Signature: _____