Cardiac Surgical Associates

PATIENT QUESTIONNAIRE

Today's Date: ________________________

Please complete the following information to the best of your ability. If you are unsure about a question, or how to reply to a specific question, please notify our clinical staff. Thank you.

NAME___________________________________ **AGE**_________

EMAIL ADDRESS_____________________________________ **PHONE #**______________

CARDIOVASCULAR

	YES	NO
1. Have you ever been told you have heart disease?	❑	❑
2. Have you ever been hospitalized because of a heart problem?	❑	❑

Have you had any of the following?

	YES	NO
1. Heart attack? Date(s) ____________ ____________	❑	❑
2. Pain, pressure or tightness in chest, neck, arms, jaw or upper back?	❑	❑

A. Pain first started:
_____________days ago ____________months ago
_____________weeks ago ____________years ago

B. Frequency, severity, pattern of discomfort has been at its current level for:
_____________days ____________months
_____________weeks ____________ years

C. Current frequency of pain:
_____________episodes per day ____________episodes per month
_____________episodes per week ____________episodes per year

D. Duration of each individual episode of pain:

____________less than 1 minute ___________5 to 15 minutes

____________1 to 5 minutes ___________More than 15 minutes

Relieved by: _________Rest ___________Nitroglycerine

E. Pain occurs with:

Walking___________________With sexual activity____________________

Housework or yardwork______ In cold, windy or hot, humid weather______

Other activity_______________At rest_______________________________

Emotion/stress______________Awaken from a sound sleep______________

After meals_________________

	YES	NO
1. Have you ever had congestive heart failure?	❑	❑
2. Have you ever had shortness of breath with mild exertion?	❑	❑
3. Have you ever awakened at night because of shortness of breath?	❑	❑
4. Have you ever had swelling of ankles or feet?	❑	❑
5. Have you ever had rheumatic fever or rheumatic heart disease?	❑	❑
6. Have you ever had high blood pressure? How long?___________________ Last or usual blood pressure?___________	❑	❑
7. Have you ever had an infection in blood stream that involved the heart?	❑	❑
8. Do you ever have palpitations, skips or irregular heartbeats?	❑	❑
9. Do you ever have blackouts or fainting spells?	❑	❑
10. Do you ever have frequent dizzy spells or light-headedness?	❑	❑
11. Do you ever have pains or cramps in legs (especially in calves) while walking?	❑	❑

12. Do you have a history of phlebitis or blood clots in veins of legs? ❑ ❑

13. Do you have a history of abnormal EKG? ❑ ❑

14. Do you have a history of a heart murmur? ❑ ❑
When?_______________

Have you had any of the following tests?

	YES	NO
1. Exercise test (stress test)? Date(s) ____________________	❑	❑
2. Echocardiogram?	❑	❑
3. Holter monitor?	❑	❑
4. Heart catherization? Hospital______________________	❑	❑

Have you had any of the following procedures?

	YES	NO
1. Have you ever had heart surgery? Date(s)____________________ Hospital(s)_________________	❑	❑
2. Have you ever had varicose vein surgery? Date(s)____________________	❑	❑
3. Have you ever had surgery on arteries other than in the heart? Date(s)_____________________ Hospital(s)_________________	❑	❑
4. Have you ever had a pacemaker? Date(s)________________________ Hospital(s)_____________________ Pacemaker Model_______________	❑	❑

ALLERGIES

	YES	NO
1. Do you have allergies to iodine?	❑	❑
2. Do you have allergies or sensitivities to medications?	❑	❑

If so, list drugs(s) and describe the reaction:

____

____

MEDICATIONS

Current Medications. List all names, dosages and frequency:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

PAST MEDICAL HISTORY

Have you had serious injuries, broken bones? If so, list details and dates:

____

____

____

____

Previous Operations

	YES	**NO**
Have you ever had an operation?	❑	❑

If so, list dates:

Appendix_______________

Gall Bladder_____________

Hernia__________________

Hysterectomy____________

Prostate_________________

Other blood vessel surgery______________

Coronary Bypass__________________

Valvular heart surgery______________

Congenital heart surgery____________

Carotid surgery___________________

Aneurysm surgery_________________

	YES	**NO**
Did you have any unusual or serious childhood illness?	❑	❑

If yes, explain

____

____

____

____

FAMILY HISTORY

	Living (yes or no)	Age or Age at Death	Cause of Death
Father			
Mother			
Spouse			
Brothers			
Sisters			
Children			

Please circle illnesses occurred in blood relatives:

Diabetes	High blood pressure
Heart Disease	Kidney disease
Cancer	Tuberculosis
Stroke	Allergy
Bleeding Disorder	Other:______________________________

SOCIAL HISTORY

Date of Birth:____

Occupation:______________________________Retired:___________

Present marriage since______________________

Do you use tobacco now? Yes__________ No__________

Did you use tobacco in the past?

____ Packs per day for ______ years Stopped when?__________

Do you use alcoholic beverages?______________________________

Type:____

__________Drinks per day or week (circle)

How many years? ____________________

HEAD, EAR, EYES, NOSE, THROAT, AND MOUTH

	YES	NO
1. Do you wear glasses?	❑	❑
2. Do you have glaucoma?	❑	❑
3. Do you have cataracts?	❑	❑
4. Do you have lens implants?	❑	❑
5. Do you have visual disturbances? (i.e. double vision, temporary visual loss)	❑	❑
6. Do you have a hearing problem?	❑	❑
7. Do you wear a hearing aid?	❑	❑
8. Do you wear dentures?	❑	❑
9. Do you have mouth or gum problems?	❑	❑
10. Do you have throat problems? (i.e. hoarseness, recurrent sore throat)	❑	❑

NEUROPSYCHIATRIC

	YES	NO
1. Have you had a concussion or skull fracture?	❑	❑
2. Have you had a seizure or convulsion?	❑	❑
3. Have you had a stroke?	❑	❑
4. Have you had any muscle disorders?	❑	❑
5. Have you had any paralysis?	❑	❑
6. Do you have headaches?	❑	❑
7. Have you ever had any psychiatric problems?	❑	❑
8. Have you ever had night sweats?	❑	❑

PULMONARY

	YES	NO
1. Have you ever had pneumonia?	❑	❑
2. Have you ever had bronchitis?	❑	❑
3. Have you ever had asthma?	❑	❑
4. Have you ever had tuberculosis?	❑	❑
5. Have you ever had a blood clot in the lung?	❑	❑
6. Do you have a chronic cough?	❑	❑
7. Have you ever coughed up blood?	❑	❑
8. Have you ever had an abnormal chest x-ray?	❑	❑

GASTROINTESTINAL

	YES	NO
1. Have you ever had an ulcer?	❑	❑
2. Do you have indigestion or heartburn?	❑	❑
3. Do you have difficulty swallowing?	❑	❑
4. Have you ever vomited blood?	❑	❑
5. Have you ever passed blood from the rectum?	❑	❑
6. Do you have frequent nausea?	❑	❑
7. Do you have frequent diarrhea?	❑	❑
8. Any recent change in bowel habits?	❑	❑
9. Have you ever had hepatitis or liver disease? When?______ Cause?_______________	❑	❑
10. Have you ever had gallbladder trouble?	❑	❑
11. Do you have abdominal pain?	❑	❑
12. Is your appetite normal?	❑	❑
13. Has your weight recently changed?	❑	❑

GENITOURINARY

	YES	NO
1. Have you ever had kidney stones?	❑	❑
2. Have you ever had an infection in your Kidneys?____Bladder?____Prostate?______	❑	❑
3. Do you have any difficulty urinating?	❑	❑
4. Do you lose your urine on accident?	❑	❑
5. Have you noticed blood in your urine?	❑	❑
6. Have you had increased urination?	❑	❑
7. Do you have any history of kidney disease?	❑	❑

MUSCULOSKELETAL

	YES	NO
1. Do you have joint pain?	❑	❑
2. Do you have back pain?	❑	❑
3. Do you have a history of arthritis?	❑	❑
4. Do you have swelling in your joints?	❑	❑
5. Do you have muscle pain, tenderness or swelling?	❑	❑

6. Which joints bother you?

____

____

METABOLIC

	YES	NO
1. Do you have diabetes? How long? _________years Controlled with Diet____ Oral agents____ Insulin_________	❑	❑
2. Have you ever had thyroid problems?	❑	❑
3. Have you ever had gout?	❑	❑
4. Have you ever had elevated cholesterol or triglyceride levels?	❑	❑

HEMATOLOGIC

	YES	NO
1. Have you ever been anemic?	❑	❑
When? ______________		
2. Do you have a history of a bleeding disorder?	❑	❑
Type?______________________		

SKIN

	YES	NO
1. Do you have skin problems?	❑	❑
2. Have you ever had cancer?	❑	❑
What type? ______________		
3. Have you had a recent fever or chills?	❑	❑

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.