Tennessee Heart & Vascular

Patient Questionnaire

Patient Name_____ MR#_____ Date _____

Birthday_____ Age_____ Primary Care MD or Referring MD _____

Pharmacy/Address/City/State/Zip_____ Phone # _____

Reason for today's visit_____ Recent Testing (radiology, procedure, lab work?) ☐ **Yes** ☐ **No**

What?_____ Where? _____

Any new medical problems, hospitalizations or surgeries since your last visit? _____

Medical History:

Have you ever had? (Check Yes or No)

Yes	No			Yes	No		
☐	☐	heart attack	year?_____ hospital?_____	☐	☐	pacemaker	year?_____ hospital?_____
☐	☐	bypass surgery	year?_____ hospital?_____	☐	☐	implanted defibrillator	year?_____ hospital?_____
☐	☐	PTCA or stent	year?_____ hospital?_____	☐	☐	stroke	year?_____ hospital?_____
☐	☐	heart valve surgery	year?_____ hospital?_____				

Are you allergic to any medications? ☐ No ☐ Yes (list) _____

Are you allergic to IV Dye/Contrast? ☐ Yes ☐ No **Shellfish?** ☐ Yes ☐ No

Have you been treated for any of the following conditions? (check Yes or No)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	high blood pressure	☐	☐	high cholesterol	☐	☐	kidney problems	☐	☐	tuberculosis (TB)
☐	☐	heart failure	☐	☐	blood clots	☐	☐	rheumatic fever	☐	☐	cancer
☐	☐	blockage of the heart	☐	☐	stroke	☐	☐	hiatal hernia	☐	☐	sleep apnea
☐	☐	blockage of the neck/leg	☐	☐	diabetes	☐	☐	stomach problems	Other _____		
☐	☐	abnormal heart rhythm	☐	☐	lung disease	☐	☐	thyroid problems			

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Do you have an Advanced Plan of Care/Directive?** ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled **Occupation:** _____

Exercise? ☐ No ☐ Yes **What do you do and how often?** _____

Caffeine? ☐ No ☐ Yes **What and how much?** _____

Smoke? ☐ No ☐ Yes **How many packs per day?**_____ **How long?**_____ **Interested in Quitting?** ☐ No ☐ Yes

Alcohol? ☐ No ☐ Yes **What and how much?** _____

Recreational Drugs? ☐ No ☐ Yes **What and how much?** _____

Preventive Care History:

Have you received the annual flu vaccination? ☐ Yes ☐ No **Pneumonia vaccination within the last 5 yrs?** ☐ Yes ☐ No

Are you currently taking an Aspirin or other antiplatelet daily? ☐ Yes ☐ No **If other, what?** __

Are you currently taking Warfarin or other anticoagulant? ☐ Yes ☐ No **If other, what?** _____

Family History:

Are there members of your immediate family with the following conditions or history?

Heart Disease? ☐ Yes ☐ No ☐ Who?_____ Age of 1st episode_____

Heart surgery? ☐ Yes ☐ No ☐ Who?_____ Age of 1st episode_____

Irregular heart rhythms? ☐ Yes ☐ No ☐ Who?_____ Age of 1st episode_____