

MID AMERICA HEART, P.C. – New Patient Questionnaire

Name: _____ Date of Birth: _____

Name of doctor that referred you: _____

Reason for visit: _____

Have you been hospitalized for a heart related condition or illness? If so, when, where, and for what condition?

Do you have any of the following symptoms? (Check all that apply)

- Chest Pain
- Shortness of Breath
- Rapid Heart Beat
- Fluttering in the Chest
- Dizziness
- Fainting or Passing Out

Do you have any of the following health conditions? (Check all that apply)

- Coronary Artery Disease (blockages in your heart arteries)
- Heart Attack – If so, when and at what hospital? _____

- Arrhythmias (heart rhythm problems or irregular heart beat)
- Congestive Heart Failure (weakened heart muscle or fluid in the lungs)
- Heart Valve Disease (narrowed or leaky heart valve)
- Mitral Valve Prolapse
- Hypertension – Are you currently taking Medication? Yes No
- Renal (Kidney) Disease
- Peripheral Vascular Disease (PVD)

Do you have any family members that have been diagnosed with heart disease or stroke?

Yes No If yes, please list below the age and health condition. If family member is deceased, list age at time of death.

(Family members include: Mother, Father, Sisters, Brothers, and Grandparents.)

Relationship	Age	Condition	Deceased (Yor N)
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Do you have any medication allergies? yes no If yes, what are the medication names and what was the reaction?

Latex allergies? yes no

Previous Surgeries? None

If so, what surgery, at what hospital, and when was it?

Medical Illnesses or Conditions? None

If so, list them and how long ago were you diagnosed?

Do you smoke or have you smoked?

No

Yes, If so how many packs per day do you smoke? _____

What year did you start? _____

Quit. If so, when did you quit? _____

How many years did you smoke? _____

How many packs per day did you smoke? _____

Do you drink or have you ever been a drinker?

No

Yes, If so how many drinks a day? _____ or Week? _____ or Month? _____

What year did you start? _____

Quit. If so, when did you quit? _____

How many years did you drink? _____

How many drinks per week? _____

Have you had any of the following test or procedures done? (Check all that apply)

TEST When and Where?

Electrocardiogram (EKG) _____

Stress Test _____

Echocardiogram (echo or ultrasound of the heart) _____

Holter Monitor (heart rhythm monitor) _____

Heart Catheterization _____

Balloon angioplasty or stent placement _____

