HEARTPLACE PLANO

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HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH:_____ DATE OF VISIT:_____
EMAIL ADDRESS: _____
PRIMARY CARE PHYSICIAN: _____
OTHER PHYSICIANS (THAT YOU WISH TO RECEIVE RECORDS):_____

1. **Reason for visit**:
   - ☐ Main complaint or concern (specify): _____
   - ☐ Establish Cardiovascular Care / Risk Assessment

2. **Care Team – please identify**
   a. Primary Care Provider_____
   b. Other physicians that need to receive your cardiovascular care records
   _____

3. **Allergies (specify substance and reaction):**
   _____

4. **Medications (specify dose, frequency; include over-the-counter, supplements)**

_____

_____

_____

_____

5. **Heart/Vascular History**: *check and if applicable specify date / detail*

CONDITION	YES	NO	DATE/DETAIL
High Blood Pressure			
High Cholesterol			
Diabetes			
Congenital Heart Disease (heart defect at birth)			
Rheumatic Fever			
CONDITION	**YES**	**NO**	**DATE/DETAIL**
Coronary Artery Disease (blocked heart artery)			
Myocardial Infarction (heart attack)			
Congestive Heart Failure			

(weak heart and/or fluid in lungs)			
Valvular Heart Disease (blocked or leaky valves)			
Arrhythmia (ie: afib)			
Cardiac Surgery / Procedure			
Cerebrovascular Disease (stroke, carotid blockage)			
Peripheral Vascular Disease (leg or arm blockage)			
Aneurysm			
Deep Vein Thrombosis / Pulmonary Embolism (leg / lung clots)			
Vascular Surgery / Procedure			

6. **Family History**: do your parents and/or siblings have heart and/or vascular disease? If so please specify the problem and age it started:
   Father:_____
   Mother:_____
   Sibling(s):_____

7. **Lifestyle:**
   a. **Have you ever smoked?** (if yes, specify how much and for how many long):
   _____
   b. **Do you drink alcohol?** (if yes, specify how much and how frequently):
   _____
   c. **Do you use drugs?** (if yes, specify type and how frequently):
   _____

8. **Occupation:** _____

9. **Marital status:**
   ☐ Single ☐ Widowed
   ☐ Married ☐ Divorced

10. **Residence**: **with whom do you live?**
    ☐ Spouse

☐ Alone
☐ Other (please specify): _____

11. **Education Level:** (specify highest level): _____

12. **Children:** (specify number, age(s)): _____

13. **Surgeries:** (specify prior operations/surgeries with date):
_____
_____
_____
_____
_____

14. **Prior Testing:** (if applicable)
Last / Prior Stress Test Date: _____
Last / Prior Echocardiogram (ultrasound) Date: _____
Last / Prior Cardiac Catheterization Date: _____

15. **Other Past Medical History:**
Please list ***other (non-cardiac/vascular)*** medical problems not identified above:
_____
_____
_____
_____
_____
_____
_____
_____
_____

16. **Are you experiencing or have you recently experienced any of the following?**

☐ Activity Change
☐ Fever
☐ Weight gain
☐ Weight loss
☐ Vision change
☐ Snoring
☐ Room spinning (vertigo)
☐ Cough
☐ Coughing up blood
☐ Shortness of breath at rest
☐ Shortness of breath on exertion

- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Chest pain/discomfort
- ☐ Sweating
- ☐ Palpitations (racing/irregular heart beat)
- ☐ Shortness of breath lying flat
- ☐ Wake up short of breath
- ☐ Passing out / Loss of consciousness
- ☐ Near passing out / near fainting
- ☐ Leg swelling
- ☐ Varicose veins
- ☐ Pain in the legs
- ☐ Leg/foot ulcer/wound
- ☐ Vomiting blood
- ☐ Blood in the stool
- ☐ Acid reflux (heart burn)
- ☐ Blood in the urine
- ☐ Difficulty urinating
- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Skin sore or ulcer
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Easy bleeding
- ☐ Temperature intolerance (hot or cold)
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Tremor(s)
- ☐ Depression
- ☐ Anxiety
- ☐ Increased stress
- ☐ Dizziness
- ☐ Seizures
- ☐ Memory loss
- ☐ Drooping of the face
- ☐ Difficulty with balance
- ☐ Confusion
- ☐ Paralysis
- ☐ Numbness of limbs
- ☐ Slurred speech