Patient History Questionnaire
(Please fill out completely)

Office Use Only
Date _____
HT_____WT_____
T_____
HR_____
RR_____
BP_____
Sat _____

Patient Name_____Age _____

Date of Birth _____

Medical Doctor _____

Cardiologist _____

What is the reason for today's visit? _____

_____

Medical History

High Blood Pressure	____ Yes	____ No
Diabetes	____ Yes	____ No
Stroke or mini-stroke	____ Yes	____ No

Surgical History

List all prior surgeries _____

_____

_____

_____

List all prescriptions and over-the-counter medications you are currently taking, including dosage and how often you take it

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies you have

_____

_____

Family History

Has anyone in your family ever had heart disease? ____Yes ____No
If so, what is their relation to you _____
Has anyone in your family ever had lung disease? ____Yes ____No
If so, what is their relation to you _____

Social History

Are you married? ____Yes ____No _____Divorced ____Widowed
Number of children _____
Who do you live with? _____
Do you smoke?_____Yes ____No ____# packs per day
Have you quit smoking? ____Yes ____No When? _____
Do you drink alcohol? ____Yes ____No How much? _____
Are you employed? ____Yes ____No ____Retired
Type of employment _____

Other Medical Problems

Visual Problems	____ Yes	____ No
Date of last dental visit	_____	
Do you need dental work	____ Yes	____ No
Lung disease	____ Yes	____ No
Asthma	____ Yes	____ No
Tuberculosis	____ Yes	____ No
Bronchitis	____ Yes	____ No
Coughing up blood	____ Yes	____ No
Heart disease	____ Yes	____ No
Heart attack	____ Yes	____ No
Waking up short of breath	____ Yes	____ No
Can you lie flat and sleep	____ Yes	____ No
Rhythm problems	____ Yes	____ No
Heart murmur	____ Yes	____ No
Rheumatic fever	____ Yes	____ No
Stomach problems	____ Yes	____ No
Stomach ulcer	____ Yes	____ No
Gastric Reflux (GERD)	____ Yes	____ No
Diverticulitis	____ Yes	____ No
Bloody stools	____ Yes	____ No
Colon polyps	____ Yes	____ No
Colon cancer	____ Yes	____ No
Kidney or Bladder problems	____ Yes	____ No
Kidney stones	____ Yes	____ No
Recurrent bladder infections	____ Yes	____ No
Kidney failure	____ Yes	____ No
Dialysis	____ Yes	____ No
Prostate problems	____ Yes	____ No
Liver problems	____ Yes	____ No
Jaundice	____ Yes	____ No
Bleeding problems	____ Yes	____No
Free bleeder	____ Yes	____ No
Blood transfusion	____ Yes	____ No
Arthritis	____ Yes	____ No
Gout	____ Yes	____ No
Cancer	____ Yes	____ No
If yes, location and treatment	_____	

_____

Seizures	____ Yes	____ No
Passing out spells	____ Yes	____ No
Skin rashes	____ Yes	____ No
Prior leg vein stripping	____ Yes	____ No
Other medical problems	_____	

_____

_____