

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 Do you Vape? _____ Yes _____ No _____ How often?
Have you quit smoking? _____ Yes _____ No When? _____
Do you drink alcohol? _____ Yes _____ No How much? _____
Do you use recreational drugs? _____ Marijuana _____ CBD _____ Cocaine _____ Other _____ When was the last time?
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	_____	
