ADVANCED CARDIOVASCULAR CARE
Health Questionnaire

Name_____ Date _____
Date of Birth _____Age _____ Sex _____ Phone _____
Primary Care Physician _____ Phone _____ ___
Reason for toady's visit: _____

Present Illness	*(Please circle one)*		
Chest Pain	No	Yes	
Shortness of breath	No	Yes	
Palpitations	No	Yes	
Dizziness	No	Yes	
Leg Swelling	No	Yes	
How far can you walk?	_____		
Do you get pain in your legs when you walk?	No	Yes	

Past Medical History	*(Please circle one)*		
Heart Attack	No	Yes	When _____
Angioplasty/Stenting	No	Yes	When _____
Diabetes Mellitus	No	Yes	
Hypertension or taking medications for it	No	Yes	
High Cholesterol or being treated for it	No	Yes	
Stroke	No	Yes	When _____
Peripheral Vascular Disease	No	Yes	
Chronic Lung Disease or Asthma	No	Yes	
Bleeding disorder	No	Yes	
Other known health problems	_____		

Past Surgical History	*(Please circle one)*		
Coronary Artery Bypass Graft Surgery	No	Yes	When _____
Valve Repair or Replacement	No	Yes	When _____
Pacemaker	No	Yes	When _____
Other operations	_____		

Family History	*(Please circle one)*		
Heart Attack in a first-degree relative	No	Yes	Who/Age _____
Heart Disease in a first-degree relative	No	Yes	
Sudden Death	No	Yes	

Social History	*(Please circle one)*		
Do you smoke or have ever smoked?	No	Yes	Quit date _____
Do you drink alcohol/beer?	No	Yes	
Do you do any illicit drugs?	No	Yes	Intravenous _____

Allergies *(Please circle one)* No Yes _____

List of Current Medications along with their Doses

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____