ADVANCED HEART AND VASCULAR ASSOCIATES

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www.advancedhva.com

PATIENT HEALTH Questionnaire

Date Today:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ Male ☐ Female	**DOB:**	/ /

OVER THE LAST 2 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?

1.	Leg muscle discomfort/aches when you walk or at rest?	**Yes** ☐	**No** ☐
2.	Night burning, pain or coldness in feet or toes?	**Yes** ☐	**No** ☐
3.	Changes of color or temperature of feet?	**Yes** ☐	**No** ☐
4.	Poor healing of wounds?	**Yes** ☐	**No** ☐

PERSONAL HEALTH HISTORY

Previous or referring doctor:		Date of last physical exam:

Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Influenza/FLU	

PLEASE INDICATE WHICH NUMBER BEST DESCRIBES YOUR ANSWERS BELOW:

0 = not at all, 1 = several days , 2 = more than half days, 3 = nearly every day

		#
1.	Little interest or pleasure in doing things	
2.	Feeling down, depressed or hopeless?	
3.	Poor appetite or over eating?	
4.	Feeling bad about yourself?	
5.	Trouble Concentrating on things?	
6.	Moving or speaking so slowly that other people have noticed?	
7.	Thoughts that you would be better off dead, or hurting yourself?	

List any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next two page (s)

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)	☐ Difficult due to weight	☐ Occasionally		
	Exercise Frequency: ☐ Weekly ☐ Daily ☐ 2 times/week ☐ 3 times/week ☐ 1-2 times/week ☐ 2-3 times/week				
	☐ 3-4 times/week	☐ Less than 30 min./day ☐ 30-60 minutes/day ☐ 1-2 hours/day			
	☐ Type of Exercise: (i.e. golf, bicycling, walking, running, swim, weights):				
Diet	☐ Diabetic Diet ☐ Cardiac Diet ☐ Un-Restricted Diet ☐ Low Carbohydrate ☐ Low Fat ☐ Vegetarian ☐ Vegan				
	☐ Eat out several days a week ☐ Drink high sugar beverages ☐ Low salt Diet ☐ Low Cholesterol Diet ☐ Low Sugar Diet				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	How many cups/day?
Alcohol	**Do you drink alcohol?** ☐ Yes ☐ No		History of Alcohol Use?	☐ Yes ☐ No How many Years? _____	
Tobacco	**Are you a current smoker?** ☐ Yes ☐ No		# of years:	Year Quit Smoking:	
	Status: ☐ Former Smoker ☐ Non-Smoker ☐ Current Every day smoker ☐ Current Occasional Smoker ☐ Unknown				

FAMILY HEALTH HISTORY

PLEASE CHECK (√) ALL THAT APPLY

MEMBERS	STATUS *(deceased or alive)*	YOB	AGE	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer	Mental Disease	Unknown
FATHER										
MOTHER										
BROTHER (s) #____										
SISTER (s) #____										
SON (s) #____										
DAUGHTER (s) #____										
GRANDFATHER *(Paternal)*										
GRANDMOTHER *(Paternal)*										
GRANDFATHER *(Maternal)*										
GRANDMOTHER *(Maternal)*										
Other (s):										