NORTH TEXAS HEART CENTER

Date _____

Patient Name _____ **SS#**_____

Please take a few minutes and complete the following questionnaire to the best of your ability. Please feel free to ask for help if you do not understand a question.

Family

Marital status: (circle one)

Single Married Separated Divorced Widowed

Children: Number of sons _____ Number of daughters _____

Has your mother, father, brother or sister had the following conditions? (Circle "Y" for yes, "N" for no, or "not sure")

				WHO	***AGE***
Heart attack or angina	Y	N	not sure		
Bypass surgery	Y	N	not sure		
Heart failure	Y	N	not sure		
Stroke	Y	N	not sure		
Diabetes	Y	N	not sure		
Cancer	Y	N	not sure		
Bleeding or Clotting problems	Y	N	not sure		

Lifestyle

Type of diet: (check all that apply)

___ Low salt ___ Low fat ___ Diabetic ___ Unrestricted

What was your approximate weight 1 year ago _____

5 year ago _____

10 years ago _____

How many days a week do you exercise (on average)? _____

What type of exercise?_____

Have you **ever** smoked cigarettes?	Y	N
Do you **currently** consume alcoholic beverages?	Y	N
Do you **currently** drink caffeinated coffee, tea or colas?	Y	N
Have you ever been under the care of a cardiologist?	Y	N

Name of cardiologist _____

City, State _____

Have you ever been told you have…?

Diabetes	Y	N	not sure
High blood pressure	Y	N	not sure
High cholesterol levels	Y	N	not sure
Cancer	Y	N	not sure
Stroke	Y	N	not sure
Stomach ulcer	Y	N	not sure
Gall stones	Y	N	not sure
Hiatal hernia or GERD	Y	N	not sure

Have you had any of the following surgeries?

Heart surgery	Y	N	not sure	
Bypass or Valve or Both (please circle one if applies)				Date of surgery ___
Surgery on the blood vessels	Y	N	not sure	
Balloon angioplasty/stent	Y	N	not sure	
Pacemaker (or defibrillator)	Y	N	not sure	
Stomach or bowel surgery	Y	N	not sure	
Cancer surgery	Y	N	not sure	

Please list any other major surgery below

_____

_____

_____

_____

Current Medications:

Name	Strength	How many times a day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(additional space available on back)

Vitamins and /or Supplements:

_____ _____

_____ _____

_____ _____

_____

Please circle any symptoms that you experience:

1. CONSTITUTIONAL:

___ fatigue
___ fever
___ chills
___ sweats (day or night)
___ weight gain or loss past year

2. EYES:

___ change in vision
___ double vision
___ blurred vision

3. EARS, NOSE, MOUTH, THROAT:

___ decreased hearing
___ ringing in ears
___ nasal drainage
___ nosebleeds
___ sore throat
___ difficulty swallowing

4. CARDIOVASCULAR/RESPIRATORY:

___ chest, neck, jaw or arm aching/pressure/tightness or discomfort
___ arm numbness
___ shortness of breath ___ at night ? ___ with exertion?
___ fatigue
___ irregular or racing heartbeats
___ swelling of ankles or legs
___ pain in legs with walking
___ temporary numbness or weakness of one side of body
___ temporary loss of vision in either eye
___ cough - productive of sputum ___ color ? ___ blood
___ night sweats
___ wheezing
___ sleepy during day

5. GASTROINTESTINAL:

___ decreased appetite
___ abdominal discomfort
___ constipation
___ bloody or dark bowel movements

___ indigestion
___ heartburn
___ nausea
___ vomiting
___ diarrhea

6. GENITOURINARY:
___ pain on urination
___ blood in urine
___ frequent urination
___ excessive nighttime urination
___ incontinence

7. MUSCULOSKELETAL:
___ muscle pain
___ muscle weakness
___ joint pain, stiffness
___ joint swelling

8. SKIN:
___ rash
___ itching
___ growths

9. NEUROLOGICAL:
___ headache
___ weakness
___ numbness, tingling
___ seizures
___ memory loss
___ changes in vision
___ dizziness
___ fainting or near fainting

10. PSYCHIATRIC:
___ confusion
___ feelings of hopelessness
___ nervousness
___ difficulty concentrating
___ sleeplessness or early morning awakening

11. ENDOCRINE:
___ excessive thirst
___ excessive urination
___ hot or cold when others are comfortable

12. HEMATOLOGIC/LYMPHATIC:
___ easy bruising

___ nosebleeds
___ lymph node enlargement

13. ALLERGIC/IMMUNOLOGIC:
___ rashes
___ nasal drainage, stuffiness
___ frequent infections

Reviewed all data with patient

_____

Physician Signature

Date:

_____