Patient Questionnaire

Name:

DOB:

E-mail:

Phone:

Referring GP/Physician:

Insurance:

Weight in kilograms:

Height in centimeters:

Indicate reason for your visit

Chest Pain/Discomfort	Abnormal ECG	Follow up stent/surgery
Shortness of breath/oedema	Blood pressure	Pacemaker
Dizzyness/fainting/palpitations	Heart failure	Health check
Heart Murmur	Abnormal rhythm	Family screening
Fatigue	Valvular disease	DVLA/Other

Medications (name, dosage and how often)

1

2

3

4

5

6

7

8

9

10

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Side effects/Intolerances (please list all medications that had to be stopped and why)

1 _____

2 _____

Allergies (medications/latex/foods/contrast dyes. Please also describe reaction you had)

1 _____

2 _____

Cardiac Risk Factors

Tobacco: I smoke since ____years approximately ___cigarettes per day
I smoked for ____years approximately ___cigarettes per day and stopped ____years ago
I never smoked

Diabetes Yes No Type 1 (Juvenile) Type 2 (Adult Onset)

Cholesterol Have you been diagnosed with High Cholesterol? ☐ Yes ☐ No
Have you been diagnosed with High Triglycerides? ☐ Yes ☐ No

High Blood Pressure: Yes No Last recorded blood pressure if known _____/____

Family History: Has any **Female** in your family been diagnosed with heart disease before 65 years of age: Yes No
Has any **Male** in your family been diagnosed with heart disease before 55 years of age? Yes No

Sudden Death in Family Yes No Any unexpected death at young age i.e. less than 45 years.

Rheumatoid Arthritis: Yes No

Kidney failure: Yes No

Underactive thyroid: Yes No

Vascular disease: Yes No How bad is the furring up of you arteries in your leg

Past Cardiac History:

Heart Failure: Yes No name of heart failure nurse if known:

Heart Attack: Yes No when?

Previous Angioplasty: Yes No when? Where?

Previous Bypass surgery: Yes No when? Where?
How many grafts?

Previous Valve surgery: Yes No when? Where?
Which valve(s)?

Previous Pacemaker/ICD: Yes No when? Where?

Previous arrhythmias ablation: Yes No when? Where?

Any known cardiac arrhythmia Yes No which?

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Past Medical History:

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

Do you drink alcohol? No Rarely Socially Occasionally Frequently Daily

Bleeding problems Yes No; which?
nosebleeds; stomach ulcers; rectal blood loss; blood loss via urinary tract; bleed in brain or in eye

Clotting problems Yes No; which?
Deep vein thrombosis (DVT); pulmonary embolus (PE); arterial clots; miscarriages; family members with clotting problems ie recurrent clots or bleeds

Functional capacity

Unlimited, I have no symptoms whatsoever
I can't do very strenuous activities without getting symptoms
I can't do light activities without getting symptoms (e.g. walking up one flight of stairs/hoovering)
I feel uncomfortable even at rest
Please rate on a scale from 0 to 100 how bad you think your symptoms are (100 is the worst you could possibly imagine) _____
Please describe what symptoms you have and how they interfere with your life.

Family History please indicate who has/had what

Any **Female** in your family with heart disease before 65 years of age? Y/N
Any **Male** in your family with heart disease before 55 years of age? Y/N

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Review of Systems

Do you have pain, discomfort or tightness in the chest, arms, or jaw?	Y/N
Have you experienced any palpitations?	Y/N
Have you experienced any excessive sweating?	Y/N
Have you fainted or felt like you were going to faint?	Y/N
Do you sleep with several pillows propped up to prevent shortness of breath?	Y/N
Do you wake up in the night feeling short of breath?	Y/N
Do you have calf-pain when you walk and is it relieved with rest?	Y/N
Have you noticed any swelling in your hands, feet or ankles?	Y/N
Have you experienced any recent weight gain?	Y/N
Have you experienced any recent weight loss?	Y/N
Have you experienced any recent fevers?	Y/N
Have you experienced any recent visual changes?	Y/N
Have you experienced any hearing loss?	Y/N
Have you been told that you snore?	Y/N
Do you stop/pause breathing during your sleep	Y/N
Have you had any recent episodes of coughing up blood?	Y/N
Have you felt any shortness of breath? Is this New?	Y/N
Have you experienced any nausea?	Y/N
Have you been experiencing any reflux/ “heartburn” ?	Y/N
Have you noticed any recent blood in your stool?	Y/N
Have you noticed any blood in your urine?	Y/N
Do you have to frequently urinate during the night?	Y/N
Have you experienced any recent episodes of dizziness?	Y/N
Have you experienced any episodes of memory loss?	Y/N
Have you had any seizures in the last year?	Y/N
Have you felt depressed recently?	Y/N
Are you experiencing any joint pain?	Y/N
Are you experiencing any recent muscle aches/pain?	Y/N

Many thanks for your time and effort. Please don't forget to bring the questionnaire to your appointment.
I look forward seeing you at my outpatient clinic.
Yours sincerely

Konrad Grosser;
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