LOWN CARDIOVASCULAR GROUP

____

New Patient Questionnaire

Thank you for taking the time to fill out this questionnaire for your Lown cardiologist. If there is any question you are not sure about, just leave it blank, and we can discuss it at your appointment.

Your Name: _______________________________ Your Age: __________Today's Date:______________

Your primary care provider: ______________________Referring physician:________________________

Where did you initially hear about the Lown Center? (e.g. family, friend, other physician, internet):

____

Please tell us about your concerns about your heart, and what you hope to gain from your visit here today? ____

____

____

Have you ever seen a heart doctor before? . . . . Yes No

Have you ever had any heart procedures, tests or surgery? . . . . Yes No

If yes, please explain____

Have you been having chest discomfort? . . . . Yes No

Do you have difficulty breathing when you walk or lie flat? . . . . Yes No

Do your ankles swell? . . . . Yes No

Has your heart been racing or skipping beats unexpectedly? . . . . Yes No

Have you passed out or felt very dizzy within the past 6 months? . . . . Yes No

Do your lower legs cramp up **when you walk**? . . . . Yes No

Have you ever had a stroke or mini-stroke? . . . . Yes No

Do you have any of the following: Diabetes High blood pressure High cholesterol

Family History

Is your mother still living? If yes, age_______If no, age at death and cause of death__________________

Is your father still living? If yes, age_______If no, age at death and cause of death___________________

Do you have a brother, sister, or parent who has had heart trouble? . . . . Yes No

If "Yes," who? Can you tell us more about what type of heart problem? __________________________

____

Medical History

Please list other major medical problems that don't involve your heart: __________________________

____

Please list any major operations you have had: ____

____

Please list all hospitalizations or Emergency Room visits you have had within the last 12 months:

____

____

Have you had any of the following problems in the last few months? **(If YES, Please Circle):**

Fever or chills	Sore throat	Dizziness
General weakness	Excessive thirst	Balance problem
Excessive fatigue	Excessive hunger	Falls
Weight loss	Arthritis pain	Seizures
Weight gain	Back pain	Slurred speech
Vision loss	Joint pain / swelling	Blackouts
Cough	Muscle aches	Memory loss
Wheezing	Lower leg cramps during walking	Depression
Sputum / phlegm	Easy bruising	Anxiety
Snoring	Bleeding	Insomnia
Sleep apnea	Constipation	Hay fever
Skin rash	Heartburn	Hot flashes
Hives	Diarrhea	Menstrual irregularities (women only)
Skin cancer	Blood in stool	
Sores that don't heal	Blood in urine	
Headaches	Painful urination	
Hearing loss		

Medications

Please list all prescription and over-the-counter medications you take, including vitamins, herbs, and supplements:

Medication Name	Dose (mg)	How often do you take it?	Reason

Are there any medications you have had an allergic or bad reaction to?: ___________________________

____

Have you skipped any of your prescription medications during the past week? Yes No

Personal History / Habits

Where were you born and where did you grow up? ____

What is your marital status? _______________________Name of spouse/ partner____________________

If you have children, how many, and how old are they?____

Who lives with you? ____

What is/was your occupation? ____

Are you currently working? Yes No, Retired No, disabled

Your education: _____High school _____College _____Graduate School

Do you smoke cigarettes? Yes No, never Former smoker

If yes, how much?___________ If you used to smoke, when did you quit?_______________________

How much alcohol do you drink? _______drinks per week How many ounces of water?_______oz./day

Do you drink coffee / energy drinks / tea? If yes, how much per day?______________________________

Do you follow any special diet? . . . . Yes No

Do you limit the amount of salt you eat? . . . . Yes No

What do you do for exercise?____

Do you have a living will expressing your wishes regarding life support? . . . . Yes No

Do you have a power of attorney for health care listing someone who can make medical decisions for you in case you are not capable of doing so yourself)? .. . . Yes No

Who would make these medical decisions for you if you were unable? ___________________

Are you driving? . . . . Yes No

Lightest weight in the past 5 years: ______ lbs.; heaviest weight in past 5 years: ______ lbs.

What other health concerns do you have? ____

____

Thank you for taking the time to complete this new patient health questionnaire.