CADV Electronic Medical Record Questionnaire

Name:_____ Date of Birth:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell:_____

SSN: _____ E-mail address: _____

Emergency Contact Person (who doesn't live with you):_____

Phone Number of Emergency Contact Person:_____

Doctor's Name	Type of Doctor	Doctors Address

PAST CARDIAC HISTORY

Have you had any of the following problems:

1.	Heart attack?	Yes [ ]	No [ ]
2.	Valvular heart disease?	Yes [ ]	No [ ]
3.	Pain or discomfort in chest, arms, throat, jaw or upper back?	Yes [ ]	No [ ]
4.	Congestive Heart Failure?	Yes [ ]	No [ ]
	a. Shortness of breath with mild exertion?	Yes [ ]	No [ ]
	b. Awaken at night because of shortness of breath?	Yes [ ]	No [ ]
	c. Swelling of ankles or feet?	Yes [ ]	No [ ]
5.	High blood pressure (Hypertension)?	Yes [ ]	No [ ]
6.	Rheumatic Fever or Rheumatic Heart Disease?	Yes [ ]	No [ ]
7.	Infection in the heart (SBE or infectious endocarditis)?	Yes [ ]	No [ ]
8.	Pericarditis?	Yes [ ]	No [ ]
9.	Stroke or Mini-Stroke?	Yes [ ]	No [ ]
	Transient Ischemia Attack (TIA)?	Yes [ ]	No [ ]
10.	Palpitations, skips, irregular or abnormal heart rhythms?	Yes [ ]	No [ ]
11.	Blackouts or fainting spells?	Yes [ ]	No [ ]
12.	Frequent dizzy spells or light-headedness?	Yes [ ]	No [ ]
13.	Pains or cramps in legs (especially in calves):	Yes [ ]	No [ ]
	☐ While walking? ☐ In bed at night?		
14.	History of Phlebitis or blood clots in veins of legs?	Yes [ ]	No [ ]
15.	History of blood clots in lungs (Pulmonary Embolus)?	Yes [ ]	No [ ]
16.	History of a heart murmur?	Yes [ ]	No [ ]
17.	History of abnormal EKG (Electrocardiogram)?	Yes [ ]	No [ ]
18.	History of abnormal chest x-ray?	Yes [ ]	No [ ]
19.	Heart Catheterization, coronary angioplasty, or coronary stenting?	Yes [ ]	No [ ]
20.	Angioplasty or stenting in blood vessels other than your heart (e.g. legs)?	Yes [ ]	No [ ]

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21. Have you had heart surgery -- Bypass or heart valve surgery? Yes [ ] No [ ]
22. Surgery on arteries other than in the heart (e.g. neck, aorta, legs, etc.?) Yes [ ] No [ ]
23. Do you have a pacemaker? Yes [ ] No [ ]
24. Do you have an automatic implantable defibrillator (AICD)? Yes [ ] No [ ]

RISK FACTOR SUMMARY (Please check all that apply)

_____ Diabetes
_____ High Blood Pressure (Hypertension)
_____ High Cholesterol
_____ Overweight by more than 10 lbs
_____ Family History of Heart Disease
_____ Smoking
_____ Prior Heart Trouble
_____ No exercise
_____ Reached Menopuase

PAST MEDICAL HISTORY (Please list other medical problems such as ulcers, thyroid, liver or kidney problems, gastric reflux, rheumatoid arthritis, etc, etc)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PAST SURGICAL HISTORY What surgery did you have and when did you have it?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medication Name	Strength	Frequency	Prescribing Doctor

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ALLERGIES

Are you ALLERGIC to Iodine, radiographic contrast dye or seafood? **YES [ ] NO [ ]**

Are you ALLERGIC to any Medications? If yes, please list below **YES [ ] NO [ ]**

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

IF LIVING	**Age**	**Health**	Age at death	**IF DECEASED** Cause
Father				
Mother				
Brothers				
Sisters				

Any family history of cardiovascular disease, strokes, diabetes or cancer? Please explain: _____

_____

_____

_____

SOCIAL HISTORY AND LIFESTYLE

ALCOHOL HISTORY: Do you currently drink ❑ Yes ❑ No

How many alcoholic beverages (beer, wine, or liquor) do you drink on an average day? _____

SMOKING HISTORY: Do you currently smoke ❑ Yes ❑ No What do you smoke? _____

Number of packs per day: _____ Number of years you have smoked: _____

If you quit smoking, when did you quit: _____ Number of packs per day you smoked: _____

Number of years you smoked before you quit: _____

How many cups of caffeinated beverages do you drink on an average day? _____

Do you exercise on a regular basis? _____

MARITAL STATUS: ❑ Single ❑ Domestic Partnership ❑ Married ❑ Civil Union ❑ Divorced ❑ Widowed

How many children do you have? _____

What is the highest grade of formal education that your finished? _____

Your occupation _____

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REVIEW OF SYSTEMS

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:	**YES**	**NO**	
Decreased exercise tolerance?	☐	☐	
Fatigue?	☐	☐	
Weight Change? ☐ Gain ☐ Loss	☐	☐	
How much?_____			
Period of time?_____			
Change in Appetite?	☐	☐	
Integumentary (Skin)			
Changes in moles?	☐	☐	
Rash?	☐	☐	
Itching?	☐	☐	
Changes in hair?	☐	☐	
Changes in nails?	☐	☐	
Eyes:	**YES**	**NO**	
Do you wear glasses?	☐	☐	
Do you have blurred vision?	☐	☐	
Do you experience double vision?	☐	☐	
Do you have a history of cataracts?	☐	☐	
Glaucoma?	☐	☐	
Have you experienced visual field loss?	☐	☐	
Ears, Nose, and Throat:			
Do you have a hearing deficit?	☐	☐	
Dizziness with changing position?	☐	☐	
Chronic sinus problems?	☐	☐	
Do you have nose bleeds?	☐	☐	
Do you wear dentures?	☐	☐	
Hoarseness/Change in voice?	☐	☐	
Respiratory:			
Do you have a chronic cough?	☐	☐	
Productive?	☐	☐	
Have you coughed up blood?	☐	☐	
Do you experience shortness of breath?	☐	☐	
☐ At rest? ☐ With Activity?			
Do you wheeze?	☐	☐	
Do you snore?	☐	☐	
Cardiovascular:			
Chest pain, pressure or tightness?	☐	☐	
☐ at rest ? ☐ with activity?			
Heart palpitations (racing)?	☐	☐	
Irregular heart beats?	☐	☐	
Short of breath lying flat?	☐	☐	How many pillows do you sleep on at night?
Waking up panicky short of breath?	☐	☐	
Have you passed out?	☐	☐	
Swelling of feet or ankles?	☐	☐	
Pain in legs with walking?	☐	☐	Describe distance before pain develops
Varicose veins?	☐	☐	
Nonhealing sores on legs or feet?	☐	☐	

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Gastrointestinal System:			
Frequent nausea?	☐	☐	
Frequent vomiting?	☐	☐	
Frequent diarrhea?	☐	☐	
Problems with constipation?	☐	☐	
Blood in Stool?	☐	☐	
Gallbladder problems?	☐	☐	
Liver Problems?	☐	☐	
Genitourinary:			
Do you have pain with urination ?	☐	☐	
Blood in urine?	☐	☐	
Sense of urgency to urinate?	☐	☐	
Awaken frequently to urinate?	☐	☐	
History or bladder, kidney infection?	☐	☐	
History of kidney stones?	☐	☐	
Males: Prostate problems?	☐	☐	
Females: Post menopausal?	☐	☐	
Musculoskeletal:			
Chronic back pain?	☐	☐	
Arthritis?	☐	☐	
History of Gout?	☐	☐	
History of blood clots in legs?	☐	☐	
History of vein ligation or stripping?	☐	☐	
Neurological:			
Temporary blurred vision/loss of vision?	☐	☐	
Temporary weakness and/or tingling involving an arm or leg?	☐	☐	
Severe Headaches?	☐	☐	
Migraine Headaches?	☐	☐	
Convulsions/Seizures?	☐	☐	
Psychiatric:			
Do you have a history of depression?	☐	☐	
Do you have chronic anxiety?	☐	☐	
Endocrine:			
High Cholesterol?	☐	☐	
Diabetes?	☐	☐	
Thryoid Problems?	☐	☐	
Hematological/Immunologic			
Chronic low blood count/anemia?	☐	☐	
Bleeding problems?	☐	☐	
Seasonal Allergies?	☐	☐	
Latex Allergy?	☐	☐	

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

Signed

Date