



# Prince William Cardiology Associates

## PATIENT HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Who referred you and why: \_\_\_\_\_ Phone # \_\_\_\_\_

Family or primary care physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Drug allergies? \_\_\_\_\_

Please list all medications that you are currently taking. If more room is needed, then please **continue on the back.** →

MEDICATION	DOSAGE	HOW OFTEN TAKEN

Please list any cardiac surgeries or procedures. If more room is needed, then please **continue on the back.** →

DATE	PROCEDURES AND/OR SURGERIES

Have you EVER HAD, or do you CURRENTLY HAVE, any of the following (check if yes):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Congestive heart failure            | <input type="checkbox"/> Previous heart attack                           | <input type="checkbox"/> Sleep problems                 |
| <input type="checkbox"/> Abnormal EKG                        | <input type="checkbox"/> High cholesterol                                | <input type="checkbox"/> Kidney disorders               |
| <input type="checkbox"/> Chest pain/tightness                | <input type="checkbox"/> Dizzy spells                                    | <input type="checkbox"/> Thyroid disease                |
| <input type="checkbox"/> Irregular heart beat/palpitations   | <input type="checkbox"/> Swelling of hands, ankles, or lower extremities | <input type="checkbox"/> Anemia                         |
| <input type="checkbox"/> Atrial fibrillation                 | <input type="checkbox"/> Leg pain when walking                           | <input type="checkbox"/> Cancer                         |
| <input type="checkbox"/> Shortness of breath                 | <input type="checkbox"/> Asthma/wheezing/emphysema                       | <input type="checkbox"/> Chemotherapy/radiation         |
| <input type="checkbox"/> Difficulty breathing with exertion  | <input type="checkbox"/> Frequent coughing                               | <input type="checkbox"/> Hereditary defects/congenitive |
| <input type="checkbox"/> Throat or jaw pain                  | <input type="checkbox"/> Recent weight loss/gain                         | <input type="checkbox"/> Diabetes                       |
| <input type="checkbox"/> Left arm pain                       | <input type="checkbox"/> Arthritis/gout                                  | <input type="checkbox"/> Drug use                       |
| <input type="checkbox"/> Heart murmur or click               | <input type="checkbox"/> Numbness or tingling sensations                 | <input type="checkbox"/> Phen-Fen use                   |
| <input type="checkbox"/> High blood pressure (hypertension)  | <input type="checkbox"/> Memory loss or confusion                        | <input type="checkbox"/> Tobacco use (how often _____)  |
| <input type="checkbox"/> Stroke (cerebral vascular accident) |  | <input type="checkbox"/> Alcohol use (how often _____)  |

Has anyone in your family ever had a heart condition? If yes, describe: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Are you able to walk or exercise on a treadmill? \_\_\_\_\_

Any other issues or special concerns you would like us to be aware of? \_\_\_\_\_

The questions on this form have been accurately answered to the best of my knowledge. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_