CARDIOVASCULAR HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____

Family Physician: _____ Smoking History: _____

Occupation: _____ _____

Drug Allergies: (list medications and symptoms caused): _____

_____

Please list current medications, including any vitamins & supplements:

Previous Surgery: (list operations and dates)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:	Living	Deceased	Cause of Death	Illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Do you have any of the following?	**Yes**	**No**	**If yes, for how long?**
Chest Pain: ____ at rest or ____ with exercise	_____	_____	_____
Shortness of Breath	_____	_____	_____
Diabetes (or abnormal blood sugar)	_____	_____	_____
Increased or abnormal blood pressure	_____	_____	_____
Swelling of the Legs or Feet	_____	_____	_____
Pain in the Calves when Walking	_____	_____	_____
Heart Murmur	_____	_____	_____
History of Rheumatic Fever	_____	_____	_____
Palpitations (skipped heart beats or "rapid heart action")	_____	_____	_____
Passing out or Black-out Spells	_____	_____	_____
Have you ever had a "Heart Attack"?	_____	_____	_____
Have you ever been told you had an "Abnormal EKG"?	_____	_____	_____
History of Lung Disease	_____	_____	_____
History of Bleeding Disorder or Internal Bleeding	_____	_____	_____

Do you have an inserted device like an ICD, pacemaker or defibrillator? If so, please indicate brand:

____ St. Jude ____ Medtronic
____ Boston Scientific ____ Biotronic
Other (or unknown): _____

What single complaint bothers you the most?
(Please use reverse side or below if more room is needed) _____