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)

_____