www.amscardiology.com 215.517.1000

Cardiovascular Health Questionnaire

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Occupation: _____

Primary Care Physician: _____

Smoking History: _____

Drug Allergies (Please list medications and symptoms caused):

_____

_____

_____

Medications and Supplements
Please list all current medications, vitamins, and supplements:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Continued on next page

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Surgical History
Please list any surgeries you've had and the dates:

- _____
- _____
- _____
- _____

Family Heart Health History

Family Member	Living	Deceased	Cause of Death	Known Illnesses
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Brother(s)	☐	☐	_____	_____
Sister(s)	☐	☐	_____	_____

Your Health Symptoms

Please check if you have experienced any of the following:

Symptom/Condition	Yes	No	If Yes, for How Long?
Chest Pain (at rest or during exercise)	☐	☐	_____
Shortness of Breath	☐	☐	_____
Diabetes (high or abnormal blood sugar)	☐	☐	_____
High or Abnormal Blood Pressure	☐	☐	_____
Swelling of Legs or Feet	☐	☐	_____
Pain in the Calves when Walking	☐	☐	_____

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Heart Murmur	☐	☐	_____
History of Rheumatic Fever	☐	☐	_____
Palpitations (irregular or rapid heartbeat)	☐	☐	_____
Fainting or Black-out Episodes	☐	☐	_____
History of Heart Attack	☐	☐	_____
Abnormal EKG	☐	☐	_____
Lung Disease	☐	☐	_____
Bleeding Disorder or Internal Bleeding	☐	☐	_____

Implanted Heart Devices

Do you have an ICD, pacemaker, or defibrillator?

If yes, please indicate the device brand:

_____

Tell Us More

What health issue bothers you the most right now?
(Use the space below or the back of this form if needed.)

_____

_____

_____

_____

Thank you for trusting us with your heart health!