West Side Cardiology Associates

New Patient Health Questionnaire

Please complete this questionnaire for us. This information allows us to completely review your health. It will help facilitate your initial office visit so we may focus our time addressing your specific health concerns. Thank you.

Patient's Full Name:

Last ______________________ First ______________________ M.I. ________

REASON FOR TODAY'S VISIT ______________________________

____

GENERAL INFORMATION

Height ________ Weight ________ Gender ________ Date of Birth ________ Age ________

Referring Physician ______________________________

HEALTH HISTORY/ REVIEW OF SYSTEMS

Check, if you have a **PERSONAL HISTORY** for the following:

EYE, EAR, NOSE, THROAT

- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Thyroid disorder
- ☐ Visual changes

GASTROINTESTINAL

- ☐ Anemia
- ☐ Black or bloody stool
- ☐ Indigestion/ acid reflux
- ☐ Liver disease
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach/abdominal pain
- ☐ Ulcers
- ☐ Vomiting/Vomiting blood

GENERAL

- ☐ Cancer
- ☐ Chills/ Fever
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Pain to muscles or joints
- ☐ Sleep disorder
- ☐ Sweats
- ☐ Weight gain/ loss

GENITO/ URINARY

- ☐ Blood in urine
- ☐ Erection difficulties
- ☐ Frequent urination
- ☐ Kidney disease
- ☐ Pregnant

NEUROLOGICAL

- ☐ Loss of strength
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Stroke/TIA
- ☐ Epilepsy/ seizure disorder
- ☐ Migraines/ Headache
- ☐ Fainting spells

PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Schizophrenia

SKIN

- ☐ Bruise easily
- ☐ Rash/ Itching

CARDIAC/ PULMONARY/ VASCULAR

- ☐ Angina
- ☐ Angioplasty
- ☐ Atrial fibrillation
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood vessel disease/ surgery
- ☐ Chest pain/ Pressure/ Discomfort
- ☐ Congenital heart disease
- ☐ Congestive heart failure
- ☐ COPD/ Emphysema
- ☐ Defibrillator
- ☐ Diabetes
- ☐ Edema-(swollen legs, ankles, feet)
- ☐ Heart attack
- ☐ Heart catheterization
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Heart valve replacement
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Leg pain
- ☐ Low blood pressure
- ☐ Lung disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Passing out/ fainting
- ☐ Peripheral vascular disease
- ☐ Poor circulation
- ☐ Rapid heart rate
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Varicose Veins

FAMILY HISTORY

Check, if you have a **FAMILY HISTORY** of the following:

☐	Heart attack/Heart disease	☐	Stroke/TIA	☐	Diabetes	☐	High blood pressure
☐	Kidney disease	☐	Cancer	☐	Tuberculosis	☐	Arthritis/Gout

IF YES, Please explain ____________________

HOSPITALIZATIONS/ ILLNESSES/ INJURIES/ SURGERIES

Please list any major hospitalizations/ illnesses/ injuries and surgeries:

YEAR	HOSPITALIZATION/ ILLNESS/ INJURY/ SURGERY

SOCIAL HISTORY

Check the following that apply to you:

____ Single ____ Married ____ Widowed ____ Divorced

____ Employed ____________________ Occupation

Check the following that apply to your current or past health habits:

____ Caffeine ____ Tobacco use/Smoke ____ Street/Recreational Drug Use ____ Alcohol ____ Regular Exercise

IF YES, Please indicate type and frequency ____________________

CURRENT MEDICATIONS

Please include all prescription and nonprescription medications. Please include vitamins, supplements, aspirin, birth control medications, laxatives, breathing treatments, medicines taken "as needed", etc.

	Name of Medication	Dose	How often taken	Prescribing Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ALLERGIES

Do you have any allergies to medicines, foods, latex, iodine, contrast dye, etc? IF YES, Please complete the following:

	Name of Allergen -- what are you allergic to?	What type of reaction -- how do you react to it?
1.		
2.		
3.		

To the best of my knowledge, all the information provided regarding my health, is complete and correct. I understand that it is my responsibility to inform West Side Cardiology if I have any changes in my health, or health information.

____________________ Signature of Patient

____________________ Please print name of Patient

Reviewed by: ____________________ Physician

____________________ Date

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