Hillsboro Cardiology, P.C.

Physicians, Board Certified in Cardiovascular Diseases

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To Hillsboro Cardiology New Patients:

Please fill out this questionnaire as best you can. If you have any questions, please ask the receptionist.

Name:_____ Date:_____

DOB: _____

I. Past Medical History

A. Did you generally enjoy good health as a child and as a young adult?

_____

B. Have you been told that you had:

1. Pneumonia?_____ When?_____
2. Diabetes?_____ Age at onset?_____
3. Rheumatic fever?_____ When?_____

C. Please list your operations. Include the name of the operation, the surgeon, the hospital, and the year:

_____

_____

_____

D. Please list any drug allergies, and describe the reaction you had to the drug:

_____

_____

_____

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II. Family History

A. If your parents are alive, tell us their ages and if they are generally well. If they have died, tell us the approximate age at death, and the cause of death, as best you know it:

1. Father_____

2. Mother_____

B. Siblings. Do the same with your brothers and sisters:

_____ _____

_____ _____

_____ _____

C. Do the same with your children:

_____ _____

_____ _____

_____ _____

D. Is there a history in your family of heart attacks or other coronary problems before the age of 55? _____

E. Does high blood pressure seem to run in your family?_____

F. Does diabetes seem to run in your family?_____

III. Social History

A. What is your marital status?_____

B. If you are married, how long have you been married, and how many times?

_____

C. What is the extent of your formal education?_____

_____

D. If you work outside the home, for whom do you work, how long have you worked there, and how would you describe your day-to-day job responsibilities?

_____

_____

_____

E. What are your principal hobbies or recreational activities? _____

_____

_____

F. Do you smoke or chew tobacco? If so, how much and for how long?

_____

G. How much alcohol do you drink, on average? _____

_____

H. How much coffee, tea, or cola do you drink, on average? We are referring only to caffeine-containing beverages. _____

_____

I. Do you follow any restrictions in diet, either self-imposed or on recommendation from a physician? _____

_____

J. List your medications. Copy the exact name of the drug from the bottle, the milligram (mg) strength of the tablets, and exactly how you take it. In addition, please bring your medications, including the bottles, with you to your visit. You do not need to mention vitamins and minerals:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

IV. Review of Systems

Please check any of the following which have been recurring problems:

_____A. Headaches.
_____B. Blindness in one eye.
_____C. Episodes of double vision.
_____D. Chronic sinus drainage or pain.
_____E. Frequent nosebleeds.
_____F. Coughing up blood.
_____G. Chronic, persistent cough.
_____H. Vomiting blood.
_____I. Bright red blood in the stools.
_____J. Black, tarry stools.
_____K. Recurrent diarrhea.
_____L. Chronic constipation.
_____M. Yellow jaundice.
_____N. Blood in urine.
_____O. Waking during the night for urination.
_____P. Difficulty starting the urine stream.
_____Q. Loss of control of urine with cough or sneeze.
_____R. Bladder infections with burning or pain.
_____S. Swelling in the joints from arthritis.
_____T. Episodes of garbled speech.
_____U. Episodes of weakness or numbness over one whole side of the body.
_____V. Pain in the legs or hips with walking.