Columbia Cardiology
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Cardiology Patient Medical Questionnaire

PATIENT INFORMATION

Date: _____

Name: _____ _____ _____ Date of Birth: _____
LAST FIRST MIDDLE MM/DD/CCYY

Primary Care Physician/Provider: _____

Previous Cardiologist (if any): _____

Other Physicians/Providers: _____

_____

_____

REASON FOR TODAY'S VISIT:

_____

_____

CARDIOVASCULAR HISTORY

Please answer the following questions with any important details you can provide.
Do you have a history of:

____ Heart attack or myocardial infarction _____

____ Cardiac catheterization or coronary angiogram _____

____ Coronary angioplasty and/or heart stent _____

____ Coronary artery bypass surgery _____

____ Angina _____

____ Heart failure / cardiomyopathy _____

____ Heart valve surgery _____

____ Known heart valve condition (e.g., aortic stenosis) _____

____ Atrial fibrillation _____

____ Pacemaker _____

____ Defibrillator / ICD _____

____ Other heart rhythm condition (arrhythmia) _____

____ Stroke / TIA _____

____ Peripheral arterial/vascular disease (PAD) _____

____ Aortic aneurysm _____

____ Carotid artery disease _____

Patient Name: _____ **Date of Birth:** _____

MEDICAL HISTORY

Do you have a history of:

____ High blood pressure (hypertension)
____ High cholesterol
____ Diabetes
____ Sleep apnea
____ Heart murmur
____ Chest discomfort
____ Shortness of breath
____ Swelling, fluid retention
____ Palpitations, heart racing
____ Lightheadedness, wooziness
____ Passing out, loss of consciousness
____ Leg pains or cramps with walking

Other medical conditions/chronic illnesses:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

MEDICAL HISTORY

Other medical conditions/chronic illnesses:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____

OTHER PREVIOUS SURGERIES

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Patient Name: _____ **Date of Birth:** _____

MEDICATIONS

Name	Strength	Direction

ALLERGIES

Have you ever had an adverse or allergic reaction to:

IV dye _____

Aspirin _____

Other medications _____

_____

SOCIAL HISTORY

Do you smoke tobacco?	Yes	No	If so, how much: _____
Do you drink alcohol?	Yes	No	If so, how much: _____
Do you use recreational drugs?	Yes	No	Describe: _____
Do you consume caffeine?	Yes	No	If so, how much: _____
Do you exercise?	Yes	No	Describe: _____
Do you follow a diet?	Yes	No	Describe: _____

Occupation: _____

FAMILY HISTORY

Please list any health conditions of family members:

	History	Age	Living?
Mother			Yes No
Father			Yes No
Brother(s)			Yes No
			Yes No
			Yes No
Sister(s)			Yes No
			Yes No
			Yes No
Other(s)			Yes No
			Yes No