North Texas Heart Center New Patient Questionnaire

Patient Name: _____

Date of Birth: _____

Referring Doctor: _____

Reason for Visit: _____

Pharmacy: _____ **Pharmacy Telephone Number:** _____

Allergies: Do you have any allergies to any medications or dye? ☐ Yes ☐ No
If yes, What medications? _____

Current Medications: Please list your medications or provide a list.

Name	Strength	How many times a day?

Past Medical History: Please list your medical problems and history.

_____

_____

_____

_____

_____

_____

Please answer questions on next page.

Past Surgical History: Please list any surgeries that you have had.

_____

_____

_____

_____

_____

Family History: Has any family members had problems with their heart or had a stroke?

Relation	Problem	At what age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History: Please fill out questions below.

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children: _____

Occupation/Profession: _____ Are you retired? ☐

Are you currently smoking? ☐
If you are, How many packs per day? _____ How many years?_____

If you are not currently smoking, did you use to smoke? ☐
If yes, How many packs per day? ___ How many years? ____ When did you quit? ___

Do you currently drink alcohol? ☐
If yes, ☐ Rarely ☐ Occasionally ☐ One a day ☐ More than one a day

Stress in your life: ☐ Low ☐ Moderate ☐ High

Exercise: ☐ Activities of daily living only ☐ Active but no exercise program
☐ Exercise program: What do you do? _____

Please answer questions on next page.

Review of Systems: Please check if you have any of these symptoms.

Constitutional: ☐ fever, ☐ night sweats, ☐ weight gain (___lbs), ☐ weight loss (___ lbs), ☐ exercise intolerance

Eyes: ☐ dry eyes, ☐ irritation, ☐ vision change

Ears: ☐ difficulty hearing, ☐ ear pain
Nose: ☐ frequent nosebleeds, ☐ nose/sinus problems
Mouth/Throat: ☐ sore throat, ☐ bleeding gums, ☐ snoring, ☐ dry mouth, ☐ oral abnormalities, ☐ mouth ulcer, ☐ teeth abnormalities, ☐ mouth breathing

Cardiovascular: ☐ chest pain on exertion, ☐ arm pain on exertion, ☐ shortness of breath when walking, ☐ shortness of breath when lying down, ☐ palpitations, ☐ known heart murmur ☐ light-headed on standing

Respiratory: ☐ cough, ☐ wheezing, ☐ shortness of breath, ☐ coughing up blood, ☐ sleep apnea

Gastrointestinal: ☐ abdominal pain, ☐ vomiting, ☐ change in appetite, ☐ black or tarry stools, ☐ frequent diarrhea, ☐ vomiting blood

Genitourinary: ☐ urinary loss of control, ☐ difficulty urinating, ☐ increased urinary frequency, ☐ hematuria, ☐ incomplete emptying

Musculoskeletal: ☐ muscle aches, ☐ muscle weakness, ☐ arthralgias/joint pain, ☐ back pain, ☐ swelling in the extremities

Skin: ☐ abnormal mole, ☐ jaundice, ☐ rash, ☐ itching, ☐ dry skin, ☐ growths/lesions

Neurologic: ☐ loss of consciousness, ☐ weakness, ☐ numbness, ☐ seizures, ☐ dizziness , ☐ frequent or severe headaches, ☐ migraines, ☐ restless legs

Psych: ☐ depression, ☐ sleep disturbances, ☐ restless sleep, ☐ feeling unsafe in relationship, ☐ alcohol abuse

Endocrine: ☐ fatigue, ☐ increased thirst, ☐ hair loss, ☐ increased hair growth, ☐ cold intolerance

Hematologic/Lymphatic: ☐ swollen glands, ☐ easy bruising, ☐ excessive bleeding

Allergy/Immunologic: ☐ runny nose, ☐ sinus pressure, ☐ itching, ☐ hives, ☐ frequent sneezing