

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