Virtua | The Cardiology Group

New Patient Questionnaire

DATE: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Referring Physician:		**PCP:**

Preferred Pharmacy
(Please include Mail Order Pharmacies)

1. _____ City: _____

2. _____ City: _____

Advance Directives
☐ None ☐ DNR
☐ Health Care Proxy ☐ Living Will

Type of New Patient Visit
☐ New Patient Consult ☐ New Patient Pre-Op Clearance
Physician requesting clearance _____ Date of Surgery_____
☐ Hospital Follow/Up ☐ New Patient (Self-Referral)

Indicate Reason for Your Visit

☐ Chest Pain/ Discomfort	☐ Hypertension (High B/P)	☐ Hypotension (Low B/P)	☐ Post MI
☐ Shortness of Breath	☐ Heart Failure/ Swelling	☐ Dizziness/ Fainting	☐ Cardiomyopathy
☐ Palpitations	☐ Abnormal rhythm	☐ Heart murmur	☐ Valvular Disease
☐ Peripheral Vascular Disease	☐ Coronary Heart Disease	☐ Cardiac Follow up	☐ Fatigue
☐ Surgical Clearance	☐ Pacemaker/ ICD Follow up	☐ Testing Follow up	☐ Abnormal EKG
☐ Cath / Angioplasty Follow up	☐Post op surgery	☐ Other	

Please list all medications. Include over-the-counter medications and vitamin supplements
Additional space in back of packet if needed

Name of Drug	Strength (example: mg)	Frequency Taken (example: once a day)

Allergies to Medications

Name of Drug	Reaction You Had:

PAST MEDICAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Surgeries:

Year:	Reason:	Hospital:

Other Hospitalizations:

Existing Medical Conditions (*Sleep apnea, asthma, etc.)*

Year of Diagnosis:	Reason:	Hospital:

CARDIAC RISK FACTORS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Tobacco	Have you ever used tobacco? ☐ Yes ☐ No	Age Started _____	
		Age Stopped _____	
	Former? ☐ Yes	Year Quit _____	
	☐ Cigarettes – How many per day?: ___cigarettes or ___pack(s)		
	☐ Cigars - #/day ☐ Chew - #/day	☐ Pipe - #/day	
Diabetes	Have you been diagnosed with Diabetes?	☐ Yes	☐ No
	If yes, check one: ☐ Type I (Juvenile Onset) ☐ Type II (Adult Onset)		
Cholesterol	Have you been diagnosed with High Cholesterol?	☐ Yes	☐ No
	Have you been diagnosed with High Triglycerides?	☐ Yes	☐ No
	Have you been diagnosed with Low HDL (Good Cholesterol) syndrome?	☐ Yes	☐ No
	Have you recently had blood work for your Cholesterol level?	☐ Yes	☐ No
Blood Work	If yes, who was the ordering physician?		
	Month drawn: _____		
	☐ Quest ☐ LabCorp ☐ Doctor's Office		
Family History of Premature Coronary Artery Disease (*before age 65*)**?**		☐ Yes	☐ No
Have you been diagnosed with Peripheral Vascular Disease?		☐ Yes	☐ No

LIFESTYLE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Diet	☐ Healthy ☐ Diabetic ☐ Low Salt ☐ Weight Loss ☐ Gluten-Free ☐ Low Fat/Cholesterol ☐ Other
Exercise	Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous Type of Exercise: _____
Alcohol	Do you drink alcohol? ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Hard Liquor ☐ Rarely ☐ Socially ☐ Occasionally ☐ Frequently ☐ Daily #drinks/day: ___ Former? Year Quit _____
Caffeine	Do you consume caffeine? ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate ☐ Energy Drinks ☐ Other Amount per day: _____ cups
Children	☐ Yes ☐ No #Sons: _____ #Daughters: _____
Occupation	_____ Employment Status: ☐ Full-time ☐ Part-time ☐ Retired

FAMILY HEALTH HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

REVIEW OF SYSTEMS

Have you recently experienced any pain, discomfort or tightness in the chest, arms, upper back or jaw?	☐ Yes	☐ No
Have you experienced any palpitations?	☐ Yes	☐ No
Have you experienced any excessive sweating?	☐ Yes	☐ No
Have you fainted or felt like you were going to faint?	☐ Yes	☐ No
Do you need to sleep with several pillows propped up to prevent shortness of breath?	☐ Yes	☐ No
Do you wake up in the night feeling short of breath?	☐ Yes	☐ No
Do you experience aches/pain in your calf muscle when you walk and it is relieved with rest?	☐ Yes	☐ No
Have you noticed any swelling in your hands, feet or ankles?	☐ Yes	☐ No
Have you experienced any recent weight gain?	☐ Yes	☐ No
Have you experienced any recent weight loss?	☐ Yes	☐ No
Have you experienced any recent fevers?	☐ Yes	☐ No
Have you experienced any recent visual changes?	☐ Yes	☐ No
Have you experienced any hearing loss?	☐ Yes	☐ No
Have you been told that you snore?	☐ Yes	☐ No
Have you had any recent episodes of coughing up blood?	☐ Yes	☐ No
Have you felt any shortness of breath? Is this New?	☐ Yes	☐ No
Have you experienced any nausea?	☐ Yes	☐ No
Have you been experiencing any reflux/ "heartburn" ?	☐ Yes	☐ No
Have you noticed any recent blood in your stool?	☐ Yes	☐ No
Have you noticed any blood in your urine?	☐ Yes	☐ No
Do you need to use the bathroom frequently during the night to urinate?	☐ Yes	☐ No
Have you experienced any recent episodes of dizziness?	☐ Yes	☐ No
Have you experienced any episodes of memory loss?	☐ Yes	☐ No
Have you had any seizures in the last year?	☐ Yes	☐ No
Have you felt depressed recently?	☐ Yes	☐ No
Are you experiencing any joint pain?	☐ Yes	☐ No
Are you experiencing any recent muscle aches/pain?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please use this space to add additional medications, if needed		
Name the Drug	Strength (example: mg)	Frequency Taken (example: once a day)