

CADV Electronic Medical Record Questionnaire

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

SSN: _____ E-mail address: _____

Emergency Contact Person (who doesn't live with you): _____

Phone Number of Emergency Contact Person: _____

Doctor's Name	Type of Doctor	Doctors Address

PAST CARDIAC HISTORY Have you had any of the following problems:

- | | | |
|---|---------|--------|
| 1. Heart attack? | Yes [] | No [] |
| 2. Valvular heart disease? | Yes [] | No [] |
| 3. Pain or discomfort in chest, arms, throat, jaw or upper back? | Yes [] | No [] |
| 4. Congestive Heart Failure? | Yes [] | No [] |
| a. Shortness of breath with mild exertion? | Yes [] | No [] |
| b. Awaken at night because of shortness of breath? | Yes [] | No [] |
| c. Swelling of ankles or feet? | Yes [] | No [] |
| 5. High blood pressure (Hypertension)? | Yes [] | No [] |
| 6. Rheumatic Fever or Rheumatic Heart Disease? | Yes [] | No [] |
| 7. Infection in the heart (SBE or infectious endocarditis)? | Yes [] | No [] |
| 8. Pericarditis? | Yes [] | No [] |
| 9. Stroke or Mini-Stroke? | Yes [] | No [] |
| Transient Ischemia Attack (TIA)? | Yes [] | No [] |
| 10. Palpitations, skips, irregular or abnormal heart rhythms? | Yes [] | No [] |
| 11. Blackouts or fainting spells? | Yes [] | No [] |
| 12. Frequent dizzy spells or light-headedness? | Yes [] | No [] |
| 13. Pains or cramps in legs (especially in calves): | Yes [] | No [] |
| <input type="checkbox"/> While walking? | | |
| <input type="checkbox"/> In bed at night? | | |
| 14. History of Phlebitis or blood clots in veins of legs? | Yes [] | No [] |
| 15. History of blood clots in lungs (Pulmonary Embolus)? | Yes [] | No [] |
| 16. History of a heart murmur? | Yes [] | No [] |
| 17. History of abnormal EKG (Electrocardiogram)? | Yes [] | No [] |
| 18. History of abnormal chest x-ray? | Yes [] | No [] |
| 19. Heart Catheterization, coronary angioplasty, or coronary stenting? | Yes [] | No [] |
| 20. Angioplasty or stenting in blood vessels other than your heart (e.g. legs)? | Yes [] | No [] |

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ALLERGIES

Are you ALLERGIC to Iodine, radiographic contrast dye or seafood? YES [] NO []

Are you ALLERGIC to any Medications? If yes, please list below. YES [] NO []

FAMILY MEDICAL HISTORY

IF LIVING	Age	Health	Age at death	IF DECEASED Cause
Father				
Mother				
Brothers				
Sisters				
Any family history of cardiovascular disease, strokes, diabetes or cancer? Please explain: _____				

SOCIAL HISTORY AND LIFESTYLE

ALCOHOL HISTORY: Do you currently drink Yes No
 How many alcoholic beverages (beer, wine, or liquor) do you drink on an average day? _____

SMOKING HISTORY: Do you currently smoke Yes No What do you smoke? _____
 Number of packs per day: _____ Number of years you have smoked: _____
 If you quit smoking, when did you quit: _____ Number of packs per day you smoked: _____
 Number of years you smoked before you quit: _____

How many cups of caffeinated beverages do you drink on an average day? _____
 Do you exercise on a regular basis? _____

MARITAL STATUS: Single Married Divorced Widowed
 How many children do you have? _____

What was the highest grade of formal education that you finished? _____
 Your occupation _____

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REVIEW OF SYSTEMS

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

General:

- | | YES | NO | |
|--|--------------------------|--------------------------|-------|
| Decreased exercise tolerance? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Fatigue? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Weight Change? <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| How much? _____ | | | |
| Period of time? _____ | | | |
| Change in Appetite? | <input type="checkbox"/> | <input type="checkbox"/> | |

Integumentary (Skin)

- | | | | |
|-------------------|--------------------------|--------------------------|-------|
| Changes in moles? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rash? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Itching? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Changes in hair? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Changes in nails? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Eyes:

- | | YES | NO | |
|---|--------------------------|--------------------------|-------|
| Do you wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have blurred vision? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you experience double vision? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have a history of cataracts? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you experienced visual field loss? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Ears, Nose, and Throat:

- | | | | |
|-----------------------------------|--------------------------|--------------------------|-------|
| Do you have a hearing deficit? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Dizziness with changing position? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chronic sinus problems? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you have nose bleeds? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you wear dentures? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hoarseness/Change in voice? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Respiratory:

- | | | | |
|---|--------------------------|--------------------------|-------|
| Do you have a chronic cough? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Productive? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you coughed up blood? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you experience shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> At rest? <input type="checkbox"/> With Activity? | | | |
| Do you wheeze? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Do you snore? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Cardiovascular:

- | | | | |
|---|--------------------------|--------------------------|-------|
| Chest pain, pressure or tightness? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> at rest? <input type="checkbox"/> with activity? | | | |
| Heart palpitations (racing)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Irregular heart beats? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Short of breath lying flat? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Waking up panicky short of breath? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you passed out? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Swelling of feet or ankles? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Pain in legs with walking? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Varicose veins? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Nonhealing sores on legs or feet? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

How many pillows do you sleep on at night? _____

Describe distance before pain develops _____

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Gastrointestinal System:		
Frequent nausea?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Problems with constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stool?	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems?	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary:		
Do you have pain with urination ?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Sense of urgency to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
Awaken frequently to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
History of bladder, kidney infection?	<input type="checkbox"/>	<input type="checkbox"/>
History of kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>
Males: Prostate problems?	<input type="checkbox"/>	<input type="checkbox"/>
Females: Post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal:		
Chronic back pain?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
History of Gout?	<input type="checkbox"/>	<input type="checkbox"/>
History of blood clots in legs?	<input type="checkbox"/>	<input type="checkbox"/>
History of vein ligation or stripping?	<input type="checkbox"/>	<input type="checkbox"/>
Neurological:		
Temporary blurred vision/loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>
Temporary weakness and/or tingling involving an arm or leg?	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric:		
Do you have a history of depression?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chronic anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine:		
High Cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hematological/Immunologic		
Chronic low blood count/anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Latex Allergy?	<input type="checkbox"/>	<input type="checkbox"/>

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

Signed _____

Date _____