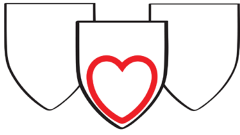

Dr. Rakesh Bhargava, M.D., FRCP (C)
Cardiologist

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905-721-8564 www.heartcarecanada.com

PATIENT QUESTIONNAIRE

Name:______________________ Age:__________ Date of Visit:__________

Occupation:______________________ Marital Status:______________________

Family Doctor:______________________ Referring Doctor:______________________

Reasons For Visit: Your "Story"

CURRENT SYMPTOMS

- [ ] Chest Pain
- [ ] Palpitations
- [ ] Shortness of Breath
- [ ] Irregular Pulse
- [ ] Passing out / Fainting
- [ ] Swollen Ankles
- [ ] Anxiety / Depression
- [ ] Dizziness
- [ ] Snoring
- [ ] Acid Reflux
- [ ] Black Stool
- [ ] Bruising / Bleeding

LIST THE DRUGS THAT YOU ARE ALLERGIC TO: ☐ NO KNOWN DRUG ALLERGIES

LIST MEDICATIONS TAKEN BY YOU CURRENTLY

MEDICINE NAME	DOSAGE	FREQUENCY

PERSONAL MEDICAL HISTORY: (Please check all that apply)

☐ DIABETES	☐ HIGH CHOLESTEROL	☐ ANEURYSM
☐ THYROID DISEASE	☐ HEART VALVE DISEASE	☐ COPD / EMPHYSEMA
☐ BLEEDING DISORDER	☐ STENTS / ANGIOPLASTY	☐ SLEEP APNEA
☐ HEART ATTACK	☐ PACEMAKER / ICD	☐ KIDNEY FAILURE
☐ STROKE	☐ VALVE REPLACEMENT	☐ BYPASS SURGERY
☐ HIGH BLOOD PRESSURE	☐ CAROTID SURGERY	☐ ____________________

HOSPITAL ADMISSIONS, SURGERIES & PROCEDURES

DATE: ________________ PROCEDURE HOSPITALIZATION: ____

DATE: ________________ PROCEDURE HOSPITALIZATION: ____

PERSONAL HABIT HISTORY

Do you smoke or chew tobacco?	☐ No	☐ Yes, How much?______________________________
Did you quit smoking?	☐ No	☐ Yes, At what age?______________________________
Do you drink alcohol?	☐ No	☐ Yes, How much?______________________________
Did you quit drinking alcohol?	☐ No	☐ Yes, At what age?______________________________
Do you use recreational drugs?	☐ No	☐ Yes, Which one(s)?______________________________
Do you exercise regularly?	☐ No	☐ Yes

FAMILY HISTORY

	ALIVE	DECEASED	AGE	HISTORY
FATHER:	☐	☐	________	______________________________________
MOTHER:	☐	☐	________	______________________________________
SIBLING:	☐	☐	________	______________________________________
SIBLING:	☐	☐	________	______________________________________
SIBLING:	☐	☐	________	______________________________________

CONCERNS AND QUESTIONS THAT YOU WANT ADDRESSED ON THIS VISIT

Signature:____ Date:______________________