Heart Care

Personalized Heart Care

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

HOSPITAL ADMISSIONS, SURGERIES & PROCEDURES

DATE: _____ PROCEDURE HOSPITALIZATION: _____

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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

Please Download and Save the Filled Form to Your Computer and Email It as an Attachment to reception@heartcare.ca

Signature: _____ Date: _____