

# Hudson Valley Heart Center Medical History Questionnaire

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Problem to be evaluated** \_\_\_\_\_

Have you had any of the following:

Diabetes	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Smoking History	Y	N
Heart Disease In Family	Y	N

Have you had any of these tests/procedures:

Stress Test/Nuclear Stress Test	Y	N
Echo/Heart Ultrasound	Y	N
Cardiac Cath/Angioplasty	Y	N
Bypass Surgery	Y	N
Pacemaker	Y	N

**Please list all hospitalizations and surgical procedures (use back of page if necessary):**

<u>Hospital</u>	<u>City</u>	<u>Reason</u>	<u>Year</u>

**Please list all current medications and *doses*:**

<u>Medication</u>	<u>Dose</u>	<u>Medication</u>	<u>Dose</u>

Do you have any drug allergies: No Yes-List: \_\_\_\_\_ **Dye allergy:** No Yes

**Family History (List any major Medical problems) If deceased, Age & Cause of Death:**

**Father:** \_\_\_\_\_

**Mother:** \_\_\_\_\_

**Brother/Sister:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Retired:** Y N **Marital Status:** M S D W

**Amount Consumed per day:** **Alcohol:** \_\_\_\_\_ **Coffee/Tea:** \_\_\_\_\_

**Soft Drinks:** \_\_\_\_\_ **Illicit Drugs:** \_\_\_\_\_

If you answer **YES** to any of the following, **please** explain on another sheet of paper:

	YES	NO
Recent Weight Gain		
Recent Weight Loss		
Loss Of Hearing		
Cough		
Abdominal Pain		
Vomiting		
Constipation		
Diarrhea		
Heartburn		
Blood In Stool		
Burning w/ Urinaton		
Blood In Urine		

	YES	NO
Joint Pain		
Dizziness		
Seizure		
Double Vision		
Paralysis		
Hot Flashes		
Deepening Of The Voice		
Easy Bleeding		
Easy Bruising		
Anxiety		
Depression		

REVIEWED & SIGNED BY DOCTOR: \_\_\_\_\_

Date: \_\_\_\_\_