KAISER PERMANENTE®

# Cardiology: Patient questionnaire

(Patient label here – office use)

Please fill out this form and give it to the specialist you will be seeing today.

## Personal History

Please check the boxes below if you have had any of the following symptoms or conditions - either in the last 30 days or in the past. Check all that apply.

| Symptom or condition | Within last 30 days | In the past |
|---|---|---|
| Dizziness or fainting | ☐ | ☐ |
| Falls that caused an injury | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Shortness of breath when walking 1 to 2 blocks | ☐ | ☐ |
| Shortness of breath when climbing 1 flight of stairs | ☐ | ☐ |
| Shortness of breath when lying down | ☐ | ☐ |
| Lower leg cramps **while walking** | ☐ | ☐ |
| Bleeding problems or low iron (also called anemia) | ☐ | ☐ |
| Blood clot in leg (also called phlebitis) | ☐ | ☐ |
| High cholesterol | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Heart murmur or abnormal heart valve | ☐ | ☐ |
| Uncomfortable feeling in the chest | ☐ | ☐ |
| Chest pain with activity (also called angina) | ☐ | ☐ |
| Heart attack (also called myocardial infarction) | ☐ | ☐ |
| Swollen legs, ankles, or feet | ☐ | ☐ |
| Irregular heartbeat | ☐ | ☐ |
| **Have you had any of the following tests or procedures:** | | |
| Stress test or treadmill test: ☐ Yes ☐ No | | |
| Cardiac catheterization or angiogram: ☐ Yes ☐ No | | |
| Angioplasty or stent: ☐ Yes ☐ No | | |
| Heart surgery: ☐ Yes ☐ No<br>If so, what kind? | | |

## Habits and Lifestyle

Do you follow a special meal plan or diet (such as Atkins®, Weight Watchers®, vegetarian, low fat, or diabetic)? ☐ Yes ☐ No

If YES, which meal plan or diet do you follow? _____

Do you exercise regularly? ☐ Yes ☐ No

If YES, how many days a week? _____

**DO NOT SCAN FORM**

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**Family History**
Please complete the section below.

| | Parents | | Brothers and Sisters | | | | Children | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mother | Father | | | | | | | | |
| Age | | | | | | | | | | |
| If no longer alive, age at time of death | | | | | | | | | | |
| **Check the box under any relative that has, or had, any of the following conditions. Please check all that apply.** | | | | | | | | | | |
| High blood pressure | | | | | | | | | | |
| High cholesterol | | | | | | | | | | |
| Smoking | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Heart attack | | | | | | | | | | |
| Angina | | | | | | | | | | |
| Stent placement | | | | | | | | | | |
| Bypass surgery | | | | | | | | | | |
| Pacemaker implant | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Mini-stroke (TIA) | | | | | | | | | | |
| Carotid surgery | | | | | | | | | | |
| Aortic aneurysm | | | | | | | | | | |
| Leg-vascular surgery | | | | | | | | | | |
| Sudden death | | | | | | | | | | |
| Fast heart rate | | | | | | | | | | |