Interventional Cardiology Medical Group, Inc.

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New Patient Questionnaire

Visit Date:

A. Patient Name & Demographics

Last Name | First Name | M.I. | Date of Birth (mm/dd/yyyy)

B. Purpose of Today's Visit *(Check all that apply)*

- ☐ Chest Discomfort
- ☐ Dizziness
- ☐ Weakness
- ☐ Fluid Retention
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Air Hunger
- ☐ Cough
- ☐ Palpitations
- ☐ Swelling
- ☐ Rhythm Problem
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Medications
- ☐ Pre-Op Evaluation
- ☐ Other: _____

C. Medical History - *Do you have (or take medications for) any of these conditions?*

High Blood Pressure:	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	COPD/Asthma/Lung Disease	☐ No	☐ Yes
High Cholesterol	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Stents or Bypass Surgery	☐ No	☐ Yes	Bleeding Problems	☐ No	☐ Yes
Pacemaker or Defibrillator	☐ No	☐ Yes	Stomach or Intestinal Ulcer	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Any Known Heart Disease	☐ No	☐ Yes
Liver Disease/Hepatitis	☐ No	☐ Yes	*If yes, please specify:* _____		

Please list all other medical conditions

Have you ever had a stress test? ☐ No ☐ Yes. Date & Results: _____

D. Surgical History - *Please include dates (mm/yyyy)*

If you have never had any surgeries, please check the box to the right. ☐ No Surgeries.

Surgery	Date	Surgery	Date
Surgery	Date	Surgery	Date
Surgery	Date	Surgery	Date

E. Family History

My mother or sister developed heart disease before the age of 65.	☐ No	☐ Yes	☐ N/A
My father or brother developed heart disease before the age of 55.	☐ No	☐ Yes	☐ N/A
My parent(s) or sibling(s) have had a stroke, or peripheral vascular disease.	☐ No	☐ Yes	☐ N/A
My family member(s) have had cardiac arrest or have a defibrillator.	☐ No	☐ Yes	☐ N/A
My family member(s) have died suddenly or unexpectedly.	☐ No	☐ Yes	☐ N/A

Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

Other Family History

F. Social History

Alcohol: ☐ Never ☐ In the past ☐ Currently (how much/how often):

Tobacco: ☐ Never ☐ In the past ☐ Currently (how much/how often):
☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Hookah ☐ Other:
I quit using tobacco. How long did you use? Quit Date: mm/yyyy

Drugs: ☐ Never ☐ In the past ☐ Currently (how much/how often):
Please specify drugs used:
I quit using drugs. How long did you use? Quit Date: mm/yyyy

Caffeine: ___Cups of coffee per day. ___Cans of caffeinated drinks per day.

Exercise: ☐ I do not exercise. Exercise routine:

G. Current Medications *(enter drug name, dose, and frequency; example: aspirin 81mg daily)*

If you do not take medications, please check the box to the right. ☐ No Medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Name of your pharmacy Major cross streets ☐ Local Pick-Up ☐ Mail Order

H. Allergies/Intolerances

If you have no allergies, please check the box to the right. ☐ No Allergies

☐ Penicillin
☐ Sulfa Drugs
☐ Iodine/Contrast Material
☐ Lidocaine/Local Anesthetics
☐ Aspirin
*When I take aspirin:*_____

☐ Statins (Cholesterol Lowering Drugs)
*When I take statin:*_____
☐ _____
☐ _____
☐ _____