CARDIOVASCULAR INSTITUTE
of LOS ROBLES HOSPITAL & MEDICAL CENTER

New Patient Health Questionnaire

How were you referred to our practice? ☐ Friend/family/former patient ☐ Internet
☐ Insurance ☐ Physician: _____ Phone:_____

Other Healthcare Providers (please check the box if you would like us to send them a copy of the consult)

☐ Primary Care Physican
Name: _____
Phone : _____
Fax: _____

☐ Cardiologist
Name: _____
Phone : _____
Fax: _____

☐ Other:_____
Name: _____
Phone : _____
Fax: _____

☐ Other:_____
Name: _____
Phone : _____
Fax: _____

Present problem(s)/reason(s) for today's visit:

_____

Medical Illnesses:

☐ Hypertension ☐ Kidney Disease ☐ Stroke
☐ Coronary Artery Disease ☐ Pacemaker ☐ Heart Attack

Past Surgeries:

Procedure	Date

Past Hospitalizations (Treatment other than surgeries)

Type	Date

Do you currently smoke? ☐ No ☐ Yes # cigarettes/day: _____ Age started: _____
Have you ever been a smoker? ☐ No ☐ Yes Age quit: _____
Do you consume alcohol? ☐ No ☐ Yes Frequency: _____ Type:_____
Do you use recreational drugs? ☐ No ☐ Yes Frequency: _____ Type:_____
Do you follow a strict diet? _____
What hobbies/activities do you enjoy? _____
Do you Exercise? ☐ No ☐ Yes Frequency: Type:

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Family Medical History: Are you adopted? ☐ No ☐ Yes

Please list below any/all family members who have or have had the following:

Disease	Family member(s):	
☐ Stroke	_____	
☐ Heart disease	_____	
☐ Cancer	_____	
☐ Diabetes	_____	Type:_____
☐ Other	_____	Type:_____

Have you had any diagnostic imaging done? ☐ No ☐ Yes

Procedures	Dates
☐ Echocardiogram	_____
☐ Xray	_____
☐ Transesophageal echocardiogram	_____
☐ Angiogram	_____
☐ CT/MRI	_____

Review of Symptoms/Medical Conditions (please check all that apply)

Constitutional: ☐ Chills ☐ Daytime Sleepiness ☐ Fatigue ☐ Fever ☐ Nights Sweats ☐ None

Skin: ☐ Acne ☐ Skin Ulcers ☐ Rash ☐ Color changes around neck, underarms, legs ☐ None

Cardiovascular/circulatory/blood:

☐ Anemia	☐ Cardiovascular disease	☐ Hyperlipidemia
☐ Arrhythmia	☐ Chest pain	☐ Irregular heart beat
☐ Bleeding disorder	☐ Congestive heart failure	☐ Palpitations
☐ Blood transfusions	☐ Heart attack (MI)	☐ Stent
☐ Blood clots	☐ Hypercholesterolemia	☐ Swelling of legs/feet
☐ Bruises/bleeds easily	☐ Hypertension	☐ Other:

Respiratory/pulmonary:

☐ Asthma	☐ Chronic cough	☐ Shortness of breath
☐ Bronchitis	☐ COPD	☐ Sleep apnea
☐ Chocking/gasping	☐ Emphysema	☐ Snoring
☐ Cough with sputum	☐ Pulmonary embolism	☐ Wheezing

Do you use a CPAP ☐ Yes ☐ No

Gastrointestinal:

☐ Abdomial pain	☐ Diarrhea	☐ Nausea
☐ Bloody stools	☐ GERD	☐ Vomiting
☐ Constipation	☐ Hiatal hernia	☐ Ulcers
☐ Dark stools	☐ Indigestion/heartburn	☐ None

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Urinary: _____

Musculoskeletal:

☐ Arthritis ☐ Joint swelling ☐ Stiffness
☐ Back pain ☐ Leg cramps ☐ Osteoporosis
☐ Joint pain ☐ Musculoskeletal disease ☐ None

Endocrine:

☐ Cold intolerance ☐ Excessive hair ☐ Hypo/hyperthyroism
☐ Cushing's disease ☐ Hair loss ☐ PCOS
☐ Excessive thrist ☐ Heat intolerance ☐ Stiffness
☐ Diabetes Mellitus Date of diagnosis:_____ ☐ Osteporosis
Insulin ☐ Oral ☐ Injectable ☐ None

Neurologic:

☐ Balance problems ☐ Fainting ☐ Stroke
☐ Chronic pain ☐ Frequent headache ☐ Weakness
☐ Dizziness ☐ Memory loss ☐ None
☐ Epilepsy/seizures ☐ Numbness or tingling

Liver/Kidney:

☐ Cirrhosis/liver disease ☐ Gout ☐ Renal insufficiency
☐ Gallstone disease ☐ Kidney stones ☐ Renal failure/ESRD/dialysis

Psychological/Behavioral:

☐ Anorexia ☐ Bulimia ☐ Sleeping difficulties
☐ Anxiety ☐ Depression ☐ Suicidal thoughts
☐ Binge eating ☐ Panic attacks ☐ None
☐ Bi-polar disorder ☐ Schizophrenia

Gynecologic:

Date of last menstrual period: _____ Date of last gynecological exam: _____
Number of pregnancies: _____
Number of live births: _____ Birth vaginal or C-Section: _____

Immunologic/infectious:

☐ Auto-immune disease ☐ HIV ☐ AIDS ☐ Hepatitis ☐ None

Miscellaneous:

☐ Cancer (type): _____ Date of diagnosis: _____ Treatment:_____
☐ Cancer (type): _____ Date of diagnosis: _____ Treatment:_____
☐ Other: _____

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Patient Medication/Allergy List

Drug allergies or sensitivities: please list all allergies to drugs, foods, medical dyes/contrast or any other sensitivities
1
2
3
4
5

Please list all current medications including vitamins and herb supplements

Name of medication, dose & frequency	Start Date	Stop Date