Cardiology Associates
500 Lilly Rd NE Olympia, WA 98506
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PATIENT QUESTIONNAIRE (v2.1)

Please complete this questionnaire so that we can update your medical history.

YOUR NAME: ____
Last Name First Name Middle Initial

DATE OF BIRTH: ____________________ **PRIMARY PHYSICIAN:** ____________________

YOUR MEDICATIONS (Please include strength and frequency)

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

MEDICATION ALLERGIES

____ ____
____ ____
____ ____

YOUR PREVIOUS MEDICAL HISTORY

Have you had any of the following?

RISK FACTORS

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

HEART HISTORY

- ☐ Coronary Angioplasty Date(s)________________
- ☐ Coronary Stenting Date(s)________________
- ☐ Congestive Heart Failure Date(s)________________
- ☐ Heart Attack Date(s)________________
- ☐ Heart Surgery Date(s)________________
- ☐ Rheumatic Fever Date(s)________________

Please list all of your other illnesses and surgeries:

ILLNESSES	DATE OF ONSET

SURGERIES	DATE

(Please complete both sides)

FAMILY HISTORY
Please complete the following questions:

MARITAL STATUS
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

CHILDREN
- ☐ Daughters How many?________________________
- ☐ Sons How many?________________________

HEART ATTACKS?
☐ Father ☐ Mother ☐ Brother ☐ Sister

ANGIOPLASTY/STENT?
☐ Father ☐ Mother ☐ Brother ☐ Sister

BYPASS SURGERY?
☐ Father ☐ Mother ☐ Brother ☐ Sister

STROKES?
☐ Father ☐ Mother ☐ Brother ☐ Sister

OTHER FAMILY ILLNESSES:
____

____

SOCIAL HISTORY
Please complete the following questions:

EMPLOYMENT
- ☐ I am employed.
  - Where? ____________________
  - Doing what? ____________________
- ☐ I am disabled.
- ☐ I am retired.
- ☐ I am unemployed.

LIVING SITUATION
- ☐ I live alone.
- ☐ I live in a nursing facility.
- ☐ I live in an adult care facility.
- ☐ I live with a friend.
- ☐ I live with my family.

SMOKING HABITS
- ☐ I smoke.
  - How much? ________________ packs/day
  - How long? ________________ years
- ☐ I used to smoke.
  - How much? ________________ packs/day
  - How long? ________________ years
  - When did you stop? ________________ mos/years ago
- ☐ I never smoked.

ALCOHOL HABITS
- ☐ I drink.
  - How much beer? ________________ beers/day
  - How much liquor? ________________ glasses/day
  - How much wine? ________________ glasses/day
- ☐ I used to drink.
  - ☐ I am a recovering alcoholic.
  - ☐ I used to drink socially.
- ☐ I never drink alcohol.

RECENT HEALTH
Do you have:

GENERAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ Recent Weight Loss
- ☐ Sweats
- ☐ Other ___________

SKIN
- ☐ Rashes
- ☐ Other ___________

HEAD
- ☐ Dizziness
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Other ___________

LUNGS
- ☐ Short of Breath at Night
- ☐ Short of Breath Lying Down
- ☐ Short of Breath with Exertion
- ☐ Wheezing
- ☐ Other ___________

HEART
- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Other ___________

GASTROINTESTINAL
- ☐ Bleeding from Bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Loss of Appetite
- ☐ Other ___________

GENITOURINARY
- ☐ Burning with Urination
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Pregnancy
- ☐ Weak Kidneys
- ☐ Other ___________

EXTREMITIES
- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Difficulty Walking
- ☐ Other ___________

NEUROLOGICAL
- ☐ Coordination Difficulty
- ☐ Faints
- ☐ Forgetfulness
- ☐ Numbness
- ☐ Seizures
- ☐ Other ___________

PSYCHIATRIC
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Other ___________