MARYVALE CARDIOLOGY

1st VISIT
MEDICAL QUESTIONAIRE

Name______________________________Age _____ Today's Date________________

1. What symptoms, or problems, bother you the most? _________________________
2. Do you get chest pain or tightness? ______________________________________
3. Shortness of breath? ____
4. Palpitations (heavy heart beats)? ____
5. Dizziness, or near loss of consciousness? __________________________________
6. Ankle swelling? ____
7. Heartburn? _____ If so, what treatment?_________________________________
8. Asthma? ____
9. What medications do you take? Include dose, frequency, and length of treatment.

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Any known medication allergies? ____
What type of reaction? ____

10. Have you been to other cardiologists? Who and when? _____________________
11. Have you had cardiologic studies before? ________________________________
    Heart catheterization? ____
    Treadmill test? ____
12. What surgeries have you had? ____

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13. Nonsurgical hospitalizations in the last 10 years? ___________________________

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14. Do you smoke? _________If so how much? ____________________________
15. Do you use alcohol? _ ______ If so how much? __________________________
16. Do you use caffeine? _______If so how much? __________________________
17. Do you use cocaine or other drugs? _______________________________________
18. Have you yourself had high blood pressure?______________________________
    If so, how long?____
19. Diabetes? ____
20. High cholesterol? ____
21. What is your level of physical activity? ___________________________________
22. What is (or was) your occupation? _________________Year retired_________
23. Have you ever seen Dr. Perry, Dr. Mendoza or Dr. Vakil before? _____________