Charlotte Heart & Vascular Institute

The Arrhythmia Center

Health Questionnaire
(Please Print)

Date of Birth:_______________ Soc. Sec #:_____- _____- _____ Appt. Date:__________

Name:____

Home Address:____
Street City State Zip

Age:_____________________ Referred By:_______________________________________

Briefly explain in your own words the problems which caused you to consult a physician today:

PAST MEDICAL HISTORY

Please list any and all medical problems ____
____
____
____

Do you currently have or suffer from:

Hypertension	YES	NO
Diabetes	YES	NO
Stroke	YES	NO
High Cholesterol	YES	NO
Arrhythmia	YES	NO
Fainting	YES	NO

Have you ever had any of the following operations? (Give dates)

Tonsillectony	YES	NO	Date:
Appendectomy	YES	NO	Date:
Remove of gallbladder	YES	NO	Date:
Hysterectomy (removal of female organ)	YES	NO	Date:
Hernia Repair	YES	NO	Date:
Hemorrhoidectomy	YES	NO	Date:

Other:____
____

Have you been hospitalized for any other reason? YES NO (If yes explain and give dates)
____
____
____

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Please list all your medications name, doses and freqency on space provided below:___________

____

____

____

Are you allergic to any medications? YES NO

If “yes” please list:____
Or attach your med sheet:____

FAMILY HISTORY

Parent	Age	#Living	#Deceased	Age at death	Condition or Illness
Mother:	______	______	______	______	____________________
Father:	______	______	______	______	____________________
Brother:	______	______	______	______	____________________
Sister:	______	______	______	______	____________________
Children:	______	______	______	______	____________________
Spouse:	______	______	______	______	____________________

Have any of your relatives (parents, brothers, sisters, or children) had any of the following? (Circle below)

Heart Trouble	YES	NO
High blood pressure	YES	NO
Stroke	YES	NO
Anemia	YES	NO
Diabetes	YES	NO
Cancer	YES	NO
Bleeding disorders	YES	NO
Tuberculosis	YES	NO

SOCIAL HISTORY (Circle below)

Marital Status: Single Married Divorced Widowed

Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Do you drive?	YES	NO
Are you retired?	YES	NO

Previous employment: ____

REVIEW OF SYSTEMS (Circle below)

How do you feel in general? Excellent Good Fair Poor

Have you been able to perform your routine activities?	YES	NO
Has there been a change in your appetite?	YES	NO
Have you gained or lost more than five pounds in the last year?	YES	NO
Have you had any recent chills, fever or night sweats?	YES	NO

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HEAD, EYE, EARS

Are you troubled by unusual or severe headaches?	YES	NO
Have you had any serious head injuries?	YES	NO
Has there been any history of loss of consciousness or seizures (convulsions or epilepsy)?	YES	NO
Have you had any problems with coordination?	YES	NO
Do you wear glasses or contact lenses?	YES	NO
Are you troubled by blurred or doubled vision?	YES	NO
Have you experienced excessive watering of the eyes or have your eyes felt itchy or painful?	YES	NO
Have you been told that you have glaucoma?	YES	NO
Do you have trouble hearing normal conversations?	YES	NO
Do you have a ringing or buzzing in your ears?	YES	NO
Have you had any ear problems in the past such as recurrent infections, swimmers' ear, ruptured ear drum or discharge from the ear?	YES	NO

RESPIRATORY

Do you have any allergies (for instance hay fever)?	YES	NO
Do you have sinus trouble?	YES	NO
Do you have nose bleeds?	YES	NO
Do you have more than three cold or sore throats a year?	YES	NO
Have you had any disorders of speech, tongue or swallowing?	YES	NO
Have you had any chronic or prolonged cough?	YES	NO
Have you ever coughed up blood?	YES	NO
Have you ever had asthma or do you wheeze?	YES	NO
Have you ever had pneumonia?	YES	NO
Have you ever had tuberculosis or a positive skin test for tuberculosis?	YES	NO

CARDIAC

Do you have any known heart disease?	YES	NO
Have you ever been told that you have high blood pressure?	YES	NO
Have you ever had any chest discomfort?	YES	NO
Have you ever had a heart attack?	YES	NO
Do you become short of breath easily?	YES	NO
Do you have to sleep with your head elevated on several pillows due to shortness of breath?	YES	NO
Do you ever wake from a sleep with marked shortness of breath?	YES	NO
Do you ever feel your heart racing or pounding for no apparent reason?	YES	NO

GASTRO-INTESTINAL

Do you have frequent heartburn or indigestion?	YES	NO
Has there been any recent nausea or vomiting?	YES	NO
Have you had recent abdominal pain?	YES	NO
Do you have any history of stomach or duodenal ulcer?	YES	NO
Have you ever had yellow jaundice or hepatitis?	YES	NO
Have you noticed any changes in your bowel habits?	YES	NO
Are your stools ever black in color?	YES	NO
Do you have bright red blood or pain with bowel movements?	YES	NO

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GENTRO-URINARY

Is there any history of bladder or kidney infection?	YES	NO
Have you had any burning with urination?	YES	NO
Do you have to urinate more frequently than what is normal?	YES	NO
Do you feel an urgency to urinate?	YES	NO
Have you ever seen blood in your urine?	YES	NO
Do you have difficulty starting urination?	YES	NO
Do you ever feel like you are unable to completely empty your bladder?	YES	NO
Do you awake at night to urinate?	YES	NO

ENDOCRINE

Does heat or cold appear to bother, you one more than the other? Specify which one.________________	YES	NO
Do you have any history of thyroid problems or of being on thyroid medication?	YES	NO
Do you have excessive thirst?	YES	NO
Have you ever been told you have diabetes?	YES	NO

BLOOD

Have you been told that you are Anemic?	YES	NO
Have you ever required transfusion?	YES	NO
Do you feel you bleed easily?	YES	NO
Have you recently noted swollen lymph nodes?	YES	NO

MUSCULO-SKELETAL

Have you had any fracture or broken bones?	YES	NO
If yes please list:____		
Are you troubled by low back pain or back strain?	YES	NO
Is there any history of pain, stiffness, or swelling of joints?	YES	NO
Have you ever had swelling or collection of fluid in the legs or ankles?	YES	NO

EMOTIONAL

Do you constantly feel excessively fatigued?	YES	NO
Do you have difficulty sleeping?	YES	NO
Do you have crying spells?	YES	NO
Are you troubled by nervousness, anxiety, or tension?	YES	NO
Have you felt depressed?	YES	NO
Have you used any tranquilizers (Valium, Librium, etc.)?	YES	NO
Have you ever been hospitalized for an emotional disorder?	YES	NO
Are you under the care of a psychiatrist?	YES	NO

MENSTRUAL HISTORY (For Females Only)

Have you ever had any complications during pregnancy?	YES	NO
Do you have regular menstrual periods?	YES	NO
Are your menstrual periods abnormal in anyway?	YES	NO
Do you have severe cramping?	YES	NO
Have you had any problems with vaginal discharge?	YES	NO