PULSE CARDIOLOGY
a division of MHP

OFFICE OF DUSTIN B. FELDMAN, D.O., FACC

CARDIOVASCULAR EVALUATION QUESTIONNAIRE

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

INSTRUCTIONS: Please appropriately respond or check YES or NO to each question on both sides of this form.

1 CARDIOVASCULAR HISTORY

A. What is the major problem which brought about your visit to our office today? _____

_____

B. Recent and past cardiovascular information. (Are you having or have you had any of the following problems?)

	YES	NO
Chest pain or tightness		
Shortness of breath when active		
Need to sit up to breathe		
Irregular heart beat or skipped beats		
Rapid heart beating or heart racing		
Lightheadedness or dizziness		
Passing out spells or blackouts		
Swelling of legs		
Heart Disease of any type in the past		
Heart Attack in the past		
Have been diagnosed to have Angina Pectoris		

	YES	NO
Have taken nitroglycerin		
Rheumatic Fever in the past		
Heart Murmur in the past		
Heart Catheterization-Angiogram in the past		
High Blood Pressure-Hypertension		
Diabetes Mellitus		
Cigarette Smoking		
Family History of Heart Disease		
Use of Birth Control Pills		
Any other past heart problems		

2 OTHER PAST HISTORY (NON-CARDIOVASCULAR)

A. Medical Illness

	YES	NO
Thyroid disease		
Lung disease		
Stomach / Intestinal Ulcers		
Liver disease		
Arthritis (gout, ect.)		

	YES	NO
Cancer		
Recurrent Infections		
Stroke		
Other Medical Illness		

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B. Have you had any recent hospitalizations; if so, for what reason/symptoms were you hospitalized for? _____

C. MAJOR SURGERY (Include Year Done) _____

D. ALLERGIES TO MEDICATIONS? _____

E. ALLERGIES TO IODINE? _____

3 GENERAL (NOT HEART RELATED) SYMPTOMS OR PROBLEMS

	YES	NO
Significant weight change		
Chills or fever		
Skin Rash		
Headaches		
Cough up phlegm for at least two months each year		
Cough up blood		
Nausea or Vomiting		
Diarrhea or constipation		
Abdominal pain or indigestion		

	YES	NO
Change in color of stool		
Difficulty starting urinary stream		
Burning on urination		
Arthritis or joint pains		
Heat or cold intolerance		
Nervousness		
Difficulty sleeping		
Depression		
Other significant symptoms		

4 PERSONAL INFORMATION

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

PACKS OF CIGARETTES SMOKED PER DAY? _____

DO YOU DRINK OVER FIVE CUPS OF COFFEE PER DAY? (CIRCLE ONE) YES NO

DO YOU DRINK OVER TWO OUNCES OF ALCOHOL OR TWO BEERS PER DAY? (CIRCLE ONE) YES NO

HOW FREQUENTLY DO YOU EXERCISE PER WEEK? _____

5 FAMILY INFORMATION (ANY FAMILY HISTORY OF THE FOLLOWING)

	YES	NO
High Blood Pressure		
Diabetes Mellitus		
Cancer		

	YES	NO
Arthritis		
Kidney disease		