Health History Questionnaire

Name: _____ Date: _____

Please check all medical conditions that apply.

- ☐ Hypertension
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Palpitations
- ☐ Arrhythmias
- ☐ sleep apnea
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ Anemia
- ☐ Epilepsy
- ☐ Strokes
- ☐ Dizziness
- ☐ Renal disease
- ☐ Hepatitis
- ☐ GI disease / GERD
- ☐ Gout
- ☐ Leg cramps
- ☐ Thyroid problems
- ☐ Depression
- ☐ Heart Attack
- ☐ Heart Valve Disorder
- ☐ Angina/chest pain
- ☐ Congestive Heart Failure
- ☐ Congenital heart disease/ defect
- ☐ Shortness of breath at night
- ☐ scarlet fever
- ☐ Hypoglycemia
- ☐ COPD
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Convulsions
- ☐ TIA's
- ☐ Passing out
- ☐ Bowel problems
- ☐ Jaundice
- ☐ Ulcers
- ☐ Claudication
- ☐ Bleeding disorders
- ☐ Mental illness
- ☐ Anxiety

- ☐ Smoking _____ packs per day
- ☐ Alcohol _____ how much? _____ how often?
- ☐ Served in the military _____ when?
- ☐ Traveled outside of USA _____ where?
- ☐ Family History ☐ Father ☐ Mother ☐ Siblings ☐ Grandparents

- ☐ Allergies
  - ☐ Angio dye ☐ Penicillin ☐ Sulfa ☐ Codeine
  - ☐ Iodine ☐ Egg whites ☐ Morphine ☐ Demerol
  - ☐ Aspirin
  - ☐ Others _____

Last physical exam: _____ Where? _____
Last hospitalization: _____ Where? _____
Previous heart surgery/angiogram/angioplasty? _____