

Date: _____

Chart #: _____

Patient Information				
PATIENT NAME (LAST)		SUFFIX	FIRST	MIDDLE
STREET ADDRESS			CITY	STATE
ZIP CODE				
HOME PHONE #	WORK PHONE #	CELL PHONE #	FAX PHONE #	
SEX	BIRTHDATE	AGE	SOCIAL SECURITY #	MARITAL STATUS
PATIENT'S EMPLOYER		OCCUPATION	EMAIL ADDRESS	
SPOUSE'S NAME			SPOUSE'S WORK PHONE #	
IN CASE OF AN EMERGENCY CONTACT:		RELATIONSHIP	PHONE #	
PRIMARY CARE PHYSICIAN		REFERRING DR./D.O./P.A./N.P.		

Cardio-Respiratory Questionnaire

PREVIOUS HOSPITALIZATIONS: This information must be available prior to satisfactory completion of your evaluation. List all hospitalizations during the past 10 years. If more than 3, please list on reverse side of this form.

HOSPITAL NAME	ADDRESS	DATES	CONDITION

I am allergic to the following medications (give name of each medication):

1. Have you had any of the following?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Overweight	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Elevated cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Have any members of your family had any of the above? If yes, please list their relationship, age, condition.

2. Please list any drugs you are now using:

NAME OF DRUG	DOSAGE	HOW OFTEN

3. Have you had:

Bronchial Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Describe:

4. Do you smoke? Yes No
If yes, number of packs per day: _____

5. Have you experienced any chest discomfort?
 Yes No If yes, please answer the following:

a) What is the location of the chest discomfort?

b) What is the character of the chest discomfort? Please check one answer:

<input type="checkbox"/> Squeezing	<input type="checkbox"/> Knife-Like
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Aggravated by breathing

If different, please explain:

c) Did the pain radiate down either arm? Yes No

If yes, which arm? Left Right Both

In what portion of the arm? Upper Lower Both

d) What activities (such as excitement, exertion) appear to cause the discomfort?

Release of Information

I authorize the above named hospitals to release to Virginia Heart Institute a report of diagnosis and other medical information related to the care and treatment of the patient named above.

Signed: _____ Date: _____

6. Have you had shortness of breath? Yes No
If yes, what condition causes the shortness of breath?