Saint Luke's
CARDIOVASCULAR CONSULTANTS

Patient Health Questionnaire

Please complete this form. This information will help us to address your health concerns during your visit.

Name: _____ Date of Birth: _____

What is the main reason you are seeing a cardiologist today? _____

Are you taking medications? Y / N
If yes, please list your current medications below (including over-the-counter medications and/or supplements):

_____ _____

_____ _____

_____ _____

What pharmacy do you prefer?

Local Pharmacy Name: _____ Phone Number: _____

Address: _____

_____

Mail-Order Pharmacy Name: _____ Phone Number: _____

Do you have any drug allergies/intolerances? Y / N
If yes, please list the drug allergy/intolerance and the type of reaction_____

_____

Please list all procedures/surgeries including dates/locations if possible (including heart catherizations, angioplasty/stents, bypass surgeries, peripheral vascular studies, and electrophysiology studies):_____

_____

_____

Family History (especially heart disease, stroke, diabetes, high cholesterol, high blood pressure, murmur):
Please include the cause of death if applicable.

Mother:_____

Father:_____

Sister(s):_____

Brother(s):_____

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Please circle any current or ongoing symptoms below:

Fever	Near Fainting	Abnormally great thirst
Fatigue	Difficulty Breathing while lying flat	Bleed/Bruise Easily
Night Sweats	Palpitations	Brief Paralysis
Nosebleeds	Awaken Gasping for Air	Coordination Disturbancees
Difficulty Swallowing	Loss of Consciousness	Daytime Sleepiness
Black or Bloody Stools	Blood in Urine	Dizziness
Nausea	Cough	Focal weakness
Vomiting	Blood in Sputum	Light-headedness
Chest Pain	Shortness of Breath	loss of balance
Cramping Pain in leg(s) when walking	Sleep Disturbances due to Breathing	numbness
Bluish discoloration of skin due to poor circulation or low oxygen levels	Snoring	Tingling or "pins and needles" sensation
Shortness of Breath with Exertion	Wheezing	Rash
Irregular heartbeats	Intolerance of Cold	Joint pain
Leg Swelling		Muscle pain

Do you consume caffeine? Y / N If yes, how often? (amount and type)_____

Do you use tobacco? Y / N If yes, do you use smokeless tobacco? Y / N

Are you a former smoker? Y / N If yes, how much?_____ How long?_____ Quit date:_____

Do you use drugs? Y / N

Do you use alcohol? Y / N How many drinks per week? _____

Diet: ___ regular ___ low carb ___low salt ___diabetic ___no added salt ___weight loss
___low fat/calorie ___vegetarian ___vegan

Do you currently exercise? Y / N If yes, what type & how often? _____