Medical Record Number

Patient Name

Addressograph Stamp - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
Stanford, California 94305

HISTORY AND PHYSICAL • CARDIOVASCULAR CLINIC • PATIENT QUESTIONNAIRE

CARDIOLOGY CLINIC PATIENT QUESTIONNAIRE

Name (Last, First)	Birthdate	Age	Sex M F

Appointment Date	Cardiology Clinic Physician

Did another physician refer you? ❑ **Yes** ❑ **No**

If yes, please complete the following so that the Cardiology Clinic physician can send a report to your referring physician.

Referring MD Name ______________________________

Street Address ______________________________

City, State, Zip Code ______________________________

Phone (   ) ____________________ Fax (   ) ____________________

If you have a primary care physician other than your referring physician, please complete the following so that the Cardiology Clinic physician can send a report to your referring physician.

Primary Care MD Name ______________________________

Street Address ______________________________

City, State, Zip Code ______________________________

Phone (   ) ____________________ Fax (   ) ____________________

Would you like the information from today's Cardiology Clinic appointment sent to any physician other than those listed above? ❑ **Yes** ❑ **No**

MD Name ______________________________

Street Address ______________________________

City, State, Zip Code ______________________________

Phone (   ) ____________________ Fax (   ) ____________________

What is the reason for this appointment today in the Cardiology Clinic?

____

____

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____

____

Worksheet Only! File in Back Pocket of CV Med Clinic Chart

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Past Medical History

Have you ever been **diagnosed** with any of the following conditions or had any of procedures listed below? *Circle Yes or No. If yes, please give an explanation.*

SYSTEM	Patient Comments	Physician Comments
CARDIOVASCULAR		
Atrial Fibrillation	YES NO	
Blood Clotting Disorder	YES NO	
Carotid Artery Disorder	YES NO	
Congestive Heart Failure	YES NO	
Elevated Cholesterol	YES NO Level __________ Date__________	
Heart Murmur	YES NO	
Heart Attack/Angina	YES NO	
Heart Surgery/Angioplasty	YES NO	
High Blood Pressure	YES NO	
Prosthetic/Artificial Heart Valve	YES NO	
Blockage of Arm or Leg Blood Vessels	YES NO	
GASTROINTESTINAL / GENITOURINARY / RESPIRATORY		
Stomach Ulcers	YES NO	
Liver Disease/Hepatitis	YES NO	
Kidney/Bladder Disease	YES NO	
Lung Disease	YES NO	
Tuberculosis	YES NO	
OTHER		
Alcohol Dependency	YES NO	
Cancer	YES NO	
Diabetes	YES NO	
Drug Abuse	YES NO	
Immune System Disorder	YES NO	
Thyroid Disease	YES NO	
Toxic Exposure	YES NO	
Sexually Transmitted Disease	YES NO	

Other Medical Problems: (Please list all medical conditions not listed above)

____

____

____

____

____

____

Previous Operations/Hospitalizations:

Date	Hospital	Problem/Operation

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Current Medications

Please list any medications (prescription and non-prescription) you are currently taking (including vitamins and aspirin).

Medications	Dosage	Number Taken Daily

Allergy History

Have you ever had an allergic reaction to any medication? ❑ Yes ❑ No If yes, please list medication and reaction.

____

Social History

Birthplace: ____________ Highest grade completed in school: ____________

Current Occupation: ____________

Relationship/marital status: ____________

Who currently lives at home with you? ____________

Have you ever smoked cigarettes: ❑ Yes ❑ No

If yes, how much do you currently smoke per day? ❑ None ❑ 1/2 pack ❑ 1 pack ❑ > 1 pack

If you previously smoked, how long ago did you quit? ❑ 1 year ❑ 1 - 5 years ❑ > 5 years

How many years did you smoke? ____________

Have you had significant exposure to: Pesticides? ❑ Yes ❑ No Toxic Waste? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No Type ____________ How often/much? ____________

Do you exercise? ❑ Yes ❑ No

If yes, how much? ❑ Rarely ❑ Occasionally ❑ > 3 times per week

Dietary restrictions? ❑ Yes ❑ No

Family History:

Family Member	Age (or age at death)	Sex	Living	Medical Problems
Grandparents		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
Father			❑ Yes ❑ No	
Mother			❑ Yes ❑ No	
Siblings		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
Children		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	
		❑ M ❑ F	❑ Yes ❑ No	

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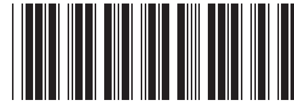

HISTORY AND PHYSICAL • CARDIOVASCULAR CLINIC •
PATIENT QUESTIONNAIRE

Review of Systems

Have you experienced any of the following symptoms? Please circle *yes, no,* or *unknown.* If yes, please give an explanation.

Physician: Please check box if WNL or record abnormalities. Leave blank if not reviewed.

SYSTEM	Patient: Circle Response			Physician / Patient Comments
ALLERGY/IMMUNOLOGY				❑ **WNL**
Low resistance to infection	YES	NO	UNKNOWN	
Environmental allergies	YES	NO	UNKNOWN	
CARDIOVASCULAR				❑ **WNL**
Chest pain or angina	YES	NO	UNKNOWN	
Irregular heart rhythm	YES	NO	UNKNOWN	
Swelling of the feet, ankles, hands	YES	NO	UNKNOWN	
CONSTITUTIONAL				❑ **WNL**
Good general health lately	YES	NO	UNKNOWN	
Recent weight changes	YES	NO	UNKNOWN	
Extreme fatigue	YES	NO	UNKNOWN	
Frequent nausea, vomiting	YES	NO	UNKNOWN	
Difficulty sleeping	YES	NO	UNKNOWN	
EARS, NOSE, MOUTH, THROAT				❑ **WNL**
Change in hearing	YES	NO	UNKNOWN	
Ringing in the ears	YES	NO	UNKNOWN	
Recent nose bleeds	YES	NO	UNKNOWN	
Chronic sinus problems	YES	NO	UNKNOWN	
Voice changes	YES	NO	UNKNOWN	
EYES				❑ **WNL**
Wear glasses, contact lenses	YES	NO	UNKNOWN	
Change in vision	YES	NO	UNKNOWN	
Glaucoma	YES	NO	UNKNOWN	
ENDOCRINE				❑ **WNL**
Heat or cold intolerance	YES	NO	UNKNOWN	
Excess thirst or urination	YES	NO	UNKNOWN	
GASTROINTESTINAL				❑ **WNL**
Change in appetite	YES	NO	UNKNOWN	
Severe heart burn	YES	NO	UNKNOWN	
Vomiting blood	YES	NO	UNKNOWN	
Frequent diarrhea	YES	NO	UNKNOWN	
Constipation	YES	NO	UNKNOWN	
Black or bloody stools	YES	NO	UNKNOWN	
Abdominal pain	YES	NO	UNKNOWN	

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SYSTEM	Patient: Circle Response			Physician / Patient Comments
GENITOURINARY				❑ **WNL**
Blood in urine	YES	NO	UNKNOWN	
Burning with urination	YES	NO	UNKNOWN	
Difficult/frequent urination	YES	NO	UNKNOWN	
Lack of bladder control	YES	NO	UNKNOWN	
Sexually transmitted disease	YES	NO	UNKNOWN	
Change in sexual function	YES	NO	UNKNOWN	
HEMATOLOGY/LYMPHATIC				❑ **WNL**
Easy bruising	YES	NO	UNKNOWN	
Frequent bleeding	YES	NO	UNKNOWN	
Enlarged lymph nodes	YES	NO	UNKNOWN	
INTEGUMENTARY SKIN & BREASTS				❑ **WNL**
Unusual or prolonged rashes	YES	NO	UNKNOWN	
Breast pain or lump	YES	NO	UNKNOWN	
Change in hair or nails	YES	NO	UNKNOWN	
MUSCULOSKELETAL				❑ **WNL**
Joint/muscle stiffness or pain	YES	NO	UNKNOWN	
Weakness of muscles or joints	YES	NO	UNKNOWN	
Back pain	YES	NO	UNKNOWN	
Difficulty walking	YES	NO	UNKNOWN	
NEUROLOGICAL				❑ **WNL**
Headaches	YES	NO	UNKNOWN	
Numbness/tingling sensation	YES	NO	UNKNOWN	
Weakness or paralysis	YES	NO	UNKNOWN	
Convulsions or seizures	YES	NO	UNKNOWN	
Change in memory/concentration	YES	NO	UNKNOWN	
Loss or blurring of vision	YES	NO	UNKNOWN	
or double vision	YES	NO	UNKNOWN	
Black-outs/dizziness	YES	NO	UNKNOWN	
Memory loss or confusion	YES	NO	UNKNOWN	
Other neurological problems	YES	NO	UNKNOWN	
PSYCHIATRIC				❑ **WNL**
Nervousness	YES	NO	UNKNOWN	
Depression	YES	NO	UNKNOWN	
Other	YES	NO	UNKNOWN	
RESPIRATORY				❑ **WNL**
Breathing problems/shortness of breath	YES	NO	UNKNOWN	
Coughing up blood	YES	NO	UNKNOWN	
Chronic cough	YES	NO	UNKNOWN	

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Attending Physician Signature ____________________ Date ____________________