THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

DIVISION OF CARDIOLOGY
HEALTH QUESTIONNAIRE

The University of Mississippi Medical Center request this information for the purpose of providing patient care. No persons outside UMMC are provided this information without your consent. If you fail to provide this information, patient care may be impaired.

If you have questions or need help completing this form, please ask for help.

Patient Name_____ **DOB**_____**MR#**_____

Who is your primary care/family doctor?_____

PERSONAL HISTORY: Check any of the following that **YOU** have had:

Anemia		Emphysema		Pneumonia	
Arthritis		Gallstones		Polio	
Asthma		Heart Attack		Rheumatic Fever	
Blood Clots/ bleeding problems		Heart Defect (from birth)		Scarlett Fever	
Cancer		Heart Murmur		Seizures	
Carotid Artery Disease		High Blood Pressure		Stroke	
Chicken Pox		Kidney Disease		Stomach Ulcer	
Congestive Heart Failure		Migraines		Thyroid Disease	
Depression		Peripheral Vascular disease		Tuberculosis	
Diabetes					

ALLERGIES TO MEDICATIONS:_____

Type of reaction:_____

PERSONAL HABITS: please circle all that apply

Tobacco: Do you now or have you ever used tobacco products? **Yes** **No** **Never**

If yes, what type? **Cigarettes** **Pipe** **Cigars** **Smokeless tobacco (chew)** **Snuff** **Vapor smoke**

When did you quit?_____

How much do / did you smoke? #_____/ per day How many years? _____

Drug Use: Do you now or have you ever used any non-medical drugs? **Yes** **No** **Never**

What type of drug?_____

Alcohol Use: Do you drink alcohol? **Yes** **No** If yes, what type? **Beer** **Wine** **Liquor**

How much? #_____drinks per day / week / month (circle one)

Caffeine: Do you drink caffeinated drinks? **Yes** **No** If yes, what type? **Coffee** **Soda** **Tea**

How much? #_____drinks per day / week / month (circle one)

Exercise: Do you exercise regularly? **Yes** **No** If yes, what type?_____

How often? _____days per week

Please continue on next page

Family History: Review the problem list below and check YES if any of your **blood relatives** have ever had the problems listed below. This includes mother, father, brother, sister, son, daughter, mother's parents or father's parents.

Problem	Y	N	Relative	Problem	Y	N	Relative
Asthma				High Blood Pressure			
Cancer				Kidney Disease			
Congestive Heart Failure				Seizures			
Diabetes				Stroke			
Heart Attack				Sudden Death			
Heart birth defect				Thyroid Disease			
Heart murmur				Tuberculosis (TB)			
Other problem							

Surgical History: Check YES if you have ever had any of the surgeries listed below. Please add any other procedures in the space below.

Surgery	Y	N	Year / Other info	Surgery	Y	N	Year / Other info
Ablation for Irregular heart rhythm				Heart valve replacement			Which valve?
Abdominal aortic aneurysm repair				Hernia surgery			
Appendectomy				Hip replacement			R / L / Both
Carotid artery surgery			R / L / Both	Hysterectomy			
Cataract surgery			R / L / Both	Knee replacement			R / L / Both
Colon surgery				Mastectomy			
Electrophysiology study				Shoulder surgery			R / L / Both
Gallbladder surgery				Stent placement			
Heart bypass surgery				Tonsillectomy			
Heart catheterization				Vascular surgery			
Other surgeries:							

Review of Symptoms: Review the problem list below and check YES if you are having the problem. Check no if you are not having the problem. Please check a box for each problem listed.

Problem	Y	N	Comments	Problem	Y	N	Comments
Fever / Chills				Heartburn			
Night sweats				Decreased appetite			
Weight loss / gain				Difficulty swallowing			
Fatigue				Abdominal pain			
Erectile dysfunction				Constipation			
Lump / swollen glands				Diarrhea			
Frequent/severe headaches				Bloody or black stools			
Vision problems				Change in bowel habits			
Ear/hearing problems				Nighttime urination			
Cough				Joint pain / stiffness			
Shortness of breath				Easy bruising / bleeding			
Wheezing				Fainting spells			
Chest pain / pressure				Dizziness			
Palpitation /heart racing				Seizures			
Swelling in ankles/ feet/ hands				Pain in calves while walking			

I verify that this information is correct.

Patient signature:_____Date_____