
Medical History Questionnaire

Fill in as much as you can. Nothing here has to be perfect from memory — bring your medication bottles and we will work through the rest together at your visit.

Reason for today's visit

What brings you in today?

When did these symptoms begin?

Current symptoms

Check anything you have experienced in the last six months.

- | | |
|--|---|
| ☐ Chest pain or pressure | ☐ Shortness of breath |
| ☐ Palpitations or skipped beats | ☐ Dizziness or lightheadedness |
| ☐ Fainting | ☐ Swelling in the legs or ankles |
| ☐ Unusual fatigue | ☐ Trouble lying flat at night |
| ☐ Leg cramping when walking | ☐ Rapid weight gain |
| ☐ Cough that will not settle | ☐ None of the above |

Cardiac history

Have you ever had a heart attack?	☐ Yes	☐ No
Have you had a cardiac catheterization?	☐ Yes	☐ No
Have you had angioplasty or a stent placed?	☐ Yes	☐ No
Have you had heart bypass or valve surgery?	☐ Yes	☐ No
Do you have a pacemaker or defibrillator?	☐ Yes	☐ No
Have you been told you have an irregular heartbeat?	☐ Yes	☐ No
Have you been told you have heart failure?	☐ Yes	☐ No
Have you ever had a stroke or mini-stroke (TIA)?	☐ Yes	☐ No

For any yes above, please give the approximate year and hospital

Other medical conditions

☐ High blood pressure	☐ High cholesterol
☐ Diabetes	☐ Thyroid disease
☐ Asthma or COPD	☐ Sleep apnea
☐ Kidney disease	☐ Liver disease
☐ Cancer	☐ Anemia or bleeding disorder
☐ Depression or anxiety	☐ Arthritis

Anything else we should know about

Current medications

Include prescriptions, over-the-counter medicines, vitamins, and supplements. Bring the bottles if it is easier.

Medication, dose, and how often

Allergies

Drug or other allergies, and the reaction each caused

Surgical history

Surgery and approximate year

Family history

We are most interested in heart disease that appeared early — before 55 in men, before 65 in women.

Heart disease, stroke, high blood pressure, diabetes, or sudden death in a parent, brother, or sister — please note who and at what age

Social history

Do you smoke or vape? How much, and for how long?

If you quit, what year?

Alcohol — how many drinks in a typical week?

Exercise — what do you do, and how often?

Signature

Patient signature

Date

Printed name

If signing for the patient,
relationship