CCMC Central Cardiology

(Physician Signature)

HEALTH APPRAISAL QUESTIONNAIRE

Patient Name: _____ Date:_____

Date of Birth:_____ Age:_____ Sex: Male ❑ Female ❑ Weight:_____ Height:_____

Marital Status: Married ❑ Divorced ❑ Widowed ❑ Single ❑

Referred By:_____

Primary Medical Doctor: _____

What is your chief complaint or reason for referral: _____

_____

History of Present Illness (Other problems associated with chief complaint/reason for referral)_____

_____

Have you or are you now experiencing any of the following?

	Yes	No
Pressure, discomfort or pain in the chest, arms, or neck?	❑	❑
Dizziness, lightheadedness, blackouts, or fainting	❑	❑
Palpitations, fast, skipped, or irregular heart beats?	❑	❑
Difficult Breathing?	❑	❑
With activity?	❑	❑
When lying flat	❑	❑

	Yes	No
Swelling of ankles, feet, or stomach?	❑	❑
Pain, discomfort, or cramping in legs when walking?	❑	❑
Temporary loss or disturbance of speech	❑	❑
Temporary weakness of one side of body?	❑	❑
Other:_____		

CURRENT/PAST MEDICAL HISTORY	Yes	No	
Coronary Heart Disease	❑	❑	Month/Year_____
Heart Attack	❑	❑	Month/Year_____
Cardiac catheterization/angiogram	❑	❑	Month/Year_____
Bypass Surgery	❑	❑	Month/Year_____
Angioplasty/stent/rotablator	❑	❑	Month/Year_____
Defibrillator	❑	❑	Month/Year_____
Pacemaker	❑	❑	Month/Year_____
Congestive Heart Failure	❑	❑	Month/Year_____
Cardiomyopathy	❑	❑	Month/Year_____
Heart Valve Disease	❑	❑	Month/Year_____
Heart Murmur	❑	❑	Month/Year_____
Heart Valve Surgery	❑	❑	Month/Year_____
Diagnosed with heart problems as a child	❑	❑	Month/Year_____
Stroke	❑	❑	Month/Year_____
Mini Stroke/TIA	❑	❑	Month/Year_____
Peripheral Vascular Disease	❑	❑	Month/Year_____
Blood clots (lungs ❑ Extremity ❑)	❑	❑	Month/Year_____
Aneurysm	❑	❑	Month/Year_____
Hypertension	❑	❑	Month/Year_____
High Cholesterol	❑	❑	Month/Year_____
Diabetes	❑	❑	Month/Year_____
Cancer (specify_____)	❑	❑	Month/Year_____
Other (specify_____)	❑	❑	Month/Year_____

List all surgeries:_____

Major Injuries:_____

Hospitalizations:_____